Authorization to Release Medical Records

☐ I elect to transfer medical records to South River Pediatrics. Please forward a copy of the records for the patient(s) listed below to the following address:

South River Pediatrics
224 Mayo Road
Edgewater, MD 21037
Fax – 410-956-6637

☐ I authorize South River Pediatrics to release medical records of the listed patient(s) to:

Physician/Practice name: _____

Street Address: _____ City, State, Zip: _____

Phone Number: _____ Fax Number: _____

☐ As patient/parent/guardian of the patient(s) listed below, I request to receive the following medical records.

Medical records requested:

☐ Immunization record ☐ Most recent physical examination ☐ Most recent lab results

☐ Visit dated: _____ ☐ Entire medical record

Patient Name	Date of Birth

Reason for transfer:

☐ Moving out of area ☐ New Insurance ☐ Other – Reason: _____

☐ Dissatisfaction - Reason: _____

I authorize the release of medical information to another provider/facility as well as authorize South River Pediatrics to obtain medical information from another provider/facility as deemed necessary in the course of my treatment. This authorization will expire sixty days from the date of signature. In the State of Maryland, the physician who creates the patient's record is the owner of those medical records. Maryland Law states that copies may be released to the patient/parent upon proper written request within a reasonable period of time. I understand that these records may contain information regarding substance abuse, psychiatric treatment or communicable diseases and this information may be released. I understand that if I request a copy of my records/child records there is a $.76 per page processing fee. In addition, request from another healthcare provider, law firm or other third party, a processing fee of $22.88 will be applied. There will also be a postage fee applied if mailed. All fees must be paid upfront before copying can begin. Request will be processed within 14 business days of receipt of payment.

_____ _____

Patient/Parent/Guardian Signature Date Print Name Relationship to Patient

_____

Phone Number

For Office Use Fees Collected: $_____ Date: _____

Date Completed: _____ Faxed: ___ Mailed: ___ For Pick-Up: ___