

CHILDREN'S MEDICAL GROUP OF SALISBURY, P.A.

217 PHILLIP MORRIS DRIVE

SALISBURY, MD 21804-1923

Tel: (410) 546-3173 Fax: (410) 742-4804

MEDICAL RECORD RELEASE AUTHORIZATION FORM

The Law requires the following information before we can release the medical records of your child.

Patient Name: _____ Date of Birth: _____

MUST CHECK ONE

___ I Authorize **Children's Medical Group of Salisbury** to **obtain ALL** my Protected Health Information from:

Name _____

Specialist _____

Address _____

City _____ State _____ Zip _____

Phone: _____ Fax: _____

OR

___ I Authorize **Children's Medical Group of Salisbury** to **release** my Protected Health Information to the following person(s) / organization(s):

Name _____

Address _____

City _____ State _____ Zip _____

Phone: _____ Fax: _____

Please Check Reason for Release:

___ Moving (New Address) _____

___ Insurance Change

___ Transition to Adult Physician

___ Unhappy with staff/provider

___ Personal Use

___ Legal Issues

___ Other (please specify) _____

Please Note: We do not copy information generated by other physician's offices.

There is a \$20.00 fee for a copy of records and a \$5.00 mailing fee.

This Authorization: Will expire in 12 months.

May be revoked in writing, but prior disclosures will not be affected.

(Signature)

(Date)

(Relationship to Patient)

(Contact phone #)