Children's Medical Group • 500 Greene Street • Cumberland • Maryland • 21502
Telephone (301) 724-7616 • Fax (301) 724-4811

Authorization for Release of Medical Records-PHI
(Complete All Bold Items)

I authorize the following Health Care Provider or other provider to release medical records (Protected Health Information) or other pertinent information about the person listed below.

Release From:

_____
_____
_____
_____

Release To:

_____
_____
_____
_____

Patient Name:_____ **DOB**:_____ **SS#**_____

This disclosure is to be used for the purpose of:

☐ Continued Treatment ☐ Insurance Claim ☐ Attorney Request ☐ Patient Request ☐ Other,specify_____

Release copies of the following record:

☐ Problem list / Visit summary
☑ Medication List
☑ Allergy list
☐ Immunization Record
☐ Growth Chart
☐ Hospital Records: _____
☐ Radiographic Studies _____
☐ Office Visit Notes _____
☐ Laboratory Test Results _____
☐ Other, specify: _____

Covering record time period from _____ to _____.
(Examples: Birth to Present, Specific Time period such as the last 5 years, 00/00/0000 to 00/00/0000, etc)

By signing this authorization, you are agreeing to the use and disclosure of certain protected health information to the recipient listed above. When information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. This authorization applies to medical records developed by CMG unless, in writing, this specifies disclosures of medical records received from another provider and that provider has not prohibited redisclosure.

I understand that this consent is valid for one year from the date of signature unless otherwise specified. I have the right to revoke this authorization in writing except to the extent that CMG has acted in reliance upon this authorization. The written revocation must be submitted to CMG's Privacy Officer at 500 Greene Street Cumberland, Maryland 21502.

Date_____ **Telephone Number**_____

Signature of parent/legal guardian/patient if >18 years of age_____

Printed Name of Signer_____**Relationship to Patient**_____

Address_____

Facility Use:
Date Received:_____ Date Information Released:_____ By Whom:_____

Information Released by what means: ☐ Fax ☐ Mail ☐ Hand Carried by the patient or representative
____ Other, specify_____
