1415 Wesley Drive
Salisbury, MD 21801
p: 410.912.7000
f: 410.912.4202

MEDICAL RECORD RELEASE AUTHORIZATION FORM

The following information is required by law before we can release the medical records of your child(ren). (See MD. Ann. Code, Health General, Title 4, Subtitle 3.)

PATIENT NAME:_____ **DATE OF BIRTH:**_____ **AGE:**_____

INCOMING TO GATEWAY

☐ I authorize release of my child(ren)'s PHI to: **GATEWAY PEDIATRICS, 1415 WESLEY DRIVE, SALISBURY, MD 21801** from

_____ Fax:_____
(Previous Primary Care Provider and/or Other Healthcare Provider)

OUTGOING

☐ I authorize **GATEWAY PEDIATRICS** to release my child(ren)'s Protected Health Information (PHI) to:

Parent/Patient/Patient Representative *(NO CHARGE FOR ELECTRONIC FORMAT; $0.76/page FOR PRINTED)*:

☐ **Email:**_____

☐ **CD via USPS:** Address: _____ City / State / Zip _____

☐ **Other Method of Delivery:**_____

Release to Other Office (PCP / Specialist) *($10.00 FEE PER CHILD)*:
(Per Maryland Law, we may charge $22.88 per child plus a per page fee, however, to ease the burden of our patient population we only charge a $10.00 fee per child.)

☐ **CD via USPS:** Name:_____ Phone #:_____

Address: _____ City / State / Zip _____

☐ **Fax:**_____

LEAVING GATEWAY PEDIATRICS? ☐ YES ☐ NO

Release to Other Party (e.g. Attorney, Insurance Company, Disability Review, etc.)*:* *Requesting Entity will be billed $22.88 per Child, a per page fee ($0.76 per page if printed or $0.57 per page if sent electronically), and postage/shipping if mailed, as per Maryland Law .*

☐ **CD:** Name:_____ Phone #:_____

Address: _____ City / State / Zip _____

REASON FOR REQUEST: ☐ Transfer to Another Provider ☐ Legal/Custody Purposes ☐ Appointment with Specialist
☐ Personal Use ☐ Moving Out of the Area ☐ Other_____

INFORMATION TO BE RELEASED:

☐ Last Well Child Visit & Immunizations ☐ Immunization Record Only ☐ Laboratory Results_____

☐ Other Specified Records_____

☐ Records **excluding** HIV Test Results, Mental Health, Drug/Alcohol Abuse, and Psychiatric/Psychotherapy Treatment.

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Per Maryland State guidelines, Gateway Pediatrics, LLC has 21 business days to release your medical records.

I authorize the release of copies of medical records and/or other information as noted above. If specifically indicated by me above I understand that this may include information concerning the following: psychiatric/psychotherapy records, mental health records, drug and alcohol treatment information, specific confidential HIV-related information, and/or any general physical condition information. I authorize this information be released by method selected above. I understand that I may revoke this authorization at any time to the extent that the person who is to make the disclosure has already acted in reliance on this authorization. If not revoked earlier, this consent will remain in effect for thirty (30) days. I understand I have a right to receive a copy of this request.

_____ _____
Signature of Parent/Guardian (or Patient if 18 years or older) Date

_____ _____
Print Name of Parent/Guardian (or Patient if 18 years or older) Relationship to Patient