

PEDIATRIC PARTNERS, LLC  
4C NORTH AVENUE  
BEL AIR, MARYLAND 21014

AUTHORIZATION FOR THE USE AND DISCLOSURE OF  
PROTECTED HEALTH INFORMATION

INFORMATION TO BE RELEASED FROM:

PEDIATRIC PARTNERS, LLC  
4C NORTH AVENUE, SUITE 400  
BEL AIR, MARYLAND 21014  
PHONE: 410-638-0239 FAX: 410-638-0282

I authorize Pediatric Partners, LLC to release medical records on:

\_\_\_\_\_  
(NAME) (DOB)

MAIL RECORDS TO:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

( ) HAVE MY RECORDS  
AVAILABLE FOR PICK UP

INFORMATION NEEDED:

\_\_\_ ALL RECORDS                      \_\_\_ LABORATORY RESULTS  
\_\_\_ HOSPITALIZATIONS              \_\_\_ OPERATIVE REPORTS  
\_\_\_ IMMUNIZATIONS                  \_\_\_ GROWTH CHART(S)

I understand that I have the right to revoke this information, in writing, at any time by sending such written notification to Pediatric Partners, LLC\*Privacy Officer\*4 C North Avenue, Suite 400, Bel Air, MD 21014. I understand that a revocation is not effective to the extent that Pediatric Partners, LLC has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may not longer be protected by federal or state law. Pediatric Partners, LLC will not base my treatment, payment, enrollment in a health plan or eligibility in a health plan for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to: Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights) and to refuse to sign this authorization.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

FORWARDING \_\_\_\_\_  
ADDRESS \_\_\_\_\_

NEW PHONE # / CELL \_\_\_\_\_

(PEDIATRIC PARTNERS, LLC CHARGES A FEE OF \$20 FOR A COPY OF A MEDICAL RECORD)