



Release of Medical Records Policy

Requests for the release of medical records must be done in writing by completing **the Pediatric Group Release of Protected Health Information Form**. Other forms of written requests (i.e., letters from parents or guardians) are not accepted. Verbal requests for the release of medical records will not be processed under any circumstances. The Pediatric Group will accept a request for the release of medical records from a physician's office when the request for release is mailed or faxed directly to the Pediatric Group.

A standard processing fee of \$20.52 will be charged for a request for release of medical records. An additional charge of .68 per page copied and postage expenses will be added to the standard processing fee. Upon receipt of the full processing fee, requests for release regarding immunization records, growth charts, last sick and well visits and other medical records will take up to 14 business days for the Pediatric Group Medical Records Department to process.

The Pediatric Group releases medical records received from other health care providers so long as the provider has not prohibited re-disclosure of the requested medical records. Requests for medical records sent to the Pediatric Group from other health care providers must be done in writing. Verbal requests for the release of medical records will not be processed under any circumstances. The request for release must include the date, name of the patient, name of the parent or guardian, name of the health care provider or the facility where the medical records originated, name of the recipient of the copied medical records and signature of the parent or guardian.

A standard processing fee of .68 per page will be charged to the requester.

Should you have any questions regarding this policy, please call the Pediatric Group Medical Records Department at 410.721.2273, ext. 8905.



The Pediatric Group and Families Too
 P.O. Box 6388
 Annapolis, Maryland 21404
 Ph: 410.721.2273
 Fax: 443.332.4401

RELEASE OF PATIENT'S/CHILD'S HEALTH INFORMATION

Date: _____

To Medical Records Department:

As the Patient/Parent or Guardian of the Patient(s) listed below, I request to receive by fax/mail a copy of the following:

- Immunization Record
- Most Recent Physical Examination
- Most Recent Lab Results
- Most Recent X-Ray Report
- Other _____

<u>Patient/Parent or Guardian Name</u>	<u>Patient's Name(s)</u>	<u>Date of Birth</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Mailing Address: _____

Fax No: _____

Phone No: _____

Signature of Patient/Parent or Guardian

Print Name

Please Allow 5-7 Business Days



RELEASE OF PROTECTED HEALTH INFORMATION FOR TRANSFER

I elect to transfer medical records to the Pediatric Group and Families Too and request that you forward a copy of the records to the individual listed below: ***(Parent/Guardian delivers to previous provider.)***

The Pediatric Group and Families Too
PO Box 6388
Annapolis, MD 21401
FAX# 443-332-4401

I authorize the Pediatric Group and Families Too to release medical records to:

Physician/Practice: _____

Street Address: _____ City, State, Zip: _____

Phone No.: _____

Please list each child whose medical record to be transferred:

<u>Patient Name(s)</u>	<u>Birth Date(s)</u>
_____	_____
_____	_____
_____	_____
_____	_____

Please indicate medical records to be transferred:

Basic Medical Records (Immunization record, growth charts, last sick and well visits)

Complete Medical Record (Immunization record, growth charts, all sick and well visits, all lab reports and x-rays ordered by the Pediatric Group. The Medical Record Staff will contact you for required fee.)

Please indicate the primary reason for transfer of medical records in order to facilitate the process:

Relocation Flexibility/Availability of Office Locations New Insurance

Dissatisfaction Reason _____

Other Reason _____

(Signature of Patient or Representative)

(Date)

(Relationship to Patient)

(Phone No.)