HOWARD COUNTY PEDIATRICS, L.L.C.

11055 Little Patuxent Pkwy, Suite103
Columbia, MD 21044
410.992.9339 Phone 410.964.5150 Fax

Authorization For the release of Protected Health Information (PHI)

Once you reach your eighteenth birthday, you are legally considered an adult in regard to medical decisions and medical care, even if you are covered by a parent's insurance plan.

Without your written consent, our doctors cannot discuss any aspects of your care with your parents. You will have to initiate all contact with us if there are questions or concerns.

Alternatively, you may sign a Consent to Release Patient Information if you would like a parent or guardian to communicate with us on your behalf.

_______________________________ _________________ ___________________________

Patient Name Date of Birth Email Address

☐ I DO NOT ALLOW ANYONE TO ACCESS MY RECORDS (skip next section and sign below)

I give the following adults permission to access my health records including, but not limited to, X-rays, immunizations, lab results, prescriptions; or to act on my behalf in my absence.

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NAME (PERSON AUTHORIZED TO ACCESS RECORDS) *RELATIONSHIP TO PATIENT*

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NAME (PERSON AUTHORIZED TO ACCESS RECORDS) *RELATIONSHIP TO PATIENT*

I ALSO ALLOW THE FOLLOWING TO BE RELEASED:

Yes	No	
☐	☐	Psychiatric Records
☐	☐	Sexual Records
☐	☐	Drug & Alcohol Records

- I understand that if the person or the entity that receives this information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
- I understand that there may be medical records from another doctor or another medical facility in my chart.
- I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment or payment or my eligibility for treatment.
- I understand I may revoke this authorization in writing at any time by submitting a written notice of my revocation, except to the extent that action has been taken in reliance on this authorization.

***This authorization shall remain in effect unless otherwise revoked in writing by the person authorizing release of Information.*

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PATIENT SIGNATURE **DATE** **CELL PHONE NUMBER**