HOWARD COUNTY PEDIATRICS, LLC

WENDELL H. MCKAY, M.D., M. CATHERINE MAILANDER, M.D.,
SYLVIA C. BANK, M.D., JENNIFER K. MOYNIHAN, M.D., DEBRA A.P. LEE, M.D.,
CYNTHIA GAO, M.D., MORUFAT KOSOKO, M.D., LIMARY GARCIA GONZALEZ, M.D.,
PRIYA J. KASTURIRANGAN, M.B.B.S., KRISTA M. SHANHOLTZ, F.N.P.C.,

Pediatrics and Adolescent Medicine

11055 Little Patuxent Parkway, Suite 103
Columbia, MD 21044
Phone 410-992-9339
Fax 410-964-5150
www.hocopeds.com

Patient Information: Print name: ________________________ DOB:____________
Print name: ________________________ DOB:____________
Print name: ________________________ DOB:____________
Print name: ________________________ DOB:____________

Please release my healthcare information from:

Name of Facility/Physician:
____

Address:_________________________
City/State/Zip:__________________________
Phone Number:_________________________
Fax Number: _________________________

Please send my healthcare records to:

Howard County Pediatrics
11055 Little Patuxent Parkway
Columbia, MD 21044
Phone: 410-992-9339
Fax: 410-964-5150

Information to be released

- ☐ Complete Medical Records
- ☐ Other (Specify): ____________________________

Purpose of Request

- ☐ Continuing Care
- ☐ Other (Specify): ____________________________

My Rights

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing, and present to the office where my information is being released. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing this disclosure of this heath information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or receive copies of the information to be used or disclosed, as provided in the Code of Federal Regulations (CFR 164.524). I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Signature: ____ Date:___________________
(Parent, Guardian, Patient)
Parent/Guardian Phone Number: ____

THIS AUTHORIZION WILL EXPIRE 90 DAYS FROM DATE SIGNED