Kensington – Gaithersburg

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

AUTORIZACION PARA TRANSFERIR INFORMACION MEDICA

PLEASE PRINT CLEARLY

TODAY'S DATE: ____/____/____ *Fecha*

PHONE NUMBER: (____) ____-____ *Numero de telefono*

PATIENT(S) NAME(S): _____ **DOB:** ____/____/____
Nombre(s) de los paciente(s) *Fecha de nacimiento*

_____ **DOB:** ____/____/____

_____ **DOB:** ____/____/____

CURRENT ADDRESS: _____
Direccion street/calle city/ciudad state & zip/estado y codigo postal

I hereby RELEASE and AUTHORIZE International Pediatrics to release the medical records of the dependent listed (or self if over the age of 18) including diagnosis, treatment, prognosis and recommendation, as well as other data pertinent to the patient's treatment to the following location listed below. I hereby state that I am the child's parent or legal guardian and have the legal right to make and/or restrict healthcare decisions regarding this child, and that my parental authority has not been terminated or restricted by the courts.

_____ _____
SIGNATURE OF PARENT/GUARDIAN/PATIENT/AUTHORIZED REPRESENTATIVE/*firma* **DATE/***fecha*

_____ _____
PRINTED NAME OF REPRESENTATIVE/*nombre del representante* **RELATIONSHIP TO PATIENT/***relacion con el paciente*

FOR RELEASE OF HIV / DRUG / ALCOHOL AND/OR PSYCHIATRIC INFORMATION, AN ADDITIONAL SIGNATURE IS REQUIRED BELOW:
Para informacion de VIH / drogas / alcohol y / o información de Psiquiatría, una firma adicional es necesaria.

_____ _____
SIGNATURE OF PARENT/GUARDIAN/PATIENT/AUTHORIZED REPRESENTATIVE/*firma* **DATE/***fecha*

DATES & TYPE OF INFORMATION TO DISCLOSE:

Fechas y tipo de información a revelar:

- ☐ **Entire medical record**/*expediente medico completo*
- ☐ **Immunization Record**/*Immunizaciones*
- ☐ **Only dates**: from/*desde* ____/____/____to/*hasta* ____/____/____
- ☐ **Other**/*otro*: _____

THE PURPOSE OF THIS REQUEST IS:

El propósito de esta informacion es:

- ☐ **Change of Physician or Insurance**/*cambio de Doctor o seguro*
- ☐ **Moving**/*cambio de direccion*
- ☐ **Personal Records**/*archivo personal*
- ☐ **Other**/*otro*: _____

CHOOSE AN OPTION BELOW/*ELIJA UNA OPCIÓN*:

☐ **REQUEST FROM/***SOLICITUD DE*:

☐ **SEND TO/***ENVIE A*:

Facility Name/*nombre del Doctor*: _____

_____

Address/*direccion*: _____

_____

_____

Phone/*telefono*: (_____) _____-_____

Fax: (_____) _____-_____

☐ **REQUEST FROM/***SOLICITUD DE*:

☐ **SEND TO/***ENVIE A*:

☐ **MAIL/***correo*? **Or/o** ☐ **FAX?**

Please do not fax if more than 25 pages

International Pediatrics

☐ Kensington	☐ Gaithersburg
10901 CONNECTICUT AVE	501 N. FREDERICK AVE
SUITE 100	SUITE 212
KENSINGTON, MD 20895	GAITHERSBURG, MD
FAX: 240-290-1045	FAX: 240-290-1045