Maryland Farms Pediatrics
5056 Thoroughbred Lane
Brentwood Tn 37027
615-373-3337
615-373-3782 fax
info@mfpeds.com
AUTHORIZATION TO RELEASE MEDICAL INFORMATION
(All sections must be completed)

I hereby authorize (practice requesting records **FROM**)
_____   Maryland Farms Pediatrics
_____   (Other Doctor) Name/Phone:_____

and its physicians' employees and agents to release or disclose to the below-named recipient all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

Patient Name: _____   **Date of Birth**: _____
I hereby authorize the release of medical records To/From:
Doctor's Office/Name:_____
Address:_____

_____
Phone Number: _____   Fax: _____
Purpose of Release: _____ Moving   _____ Changing Doctors   _____ Personal Use
This request and authorization applies to:
_____ All Medical Records   _____ Specific Date(s) of Service_____
*All records will be mailed unless otherwise specified. If you wish to have them printed to and faxed please note here: _____
If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released.
_____Substance abuse _____Psychological or psychiatric treatment _____HIV/AIDS/STD
I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which by not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sight this authorization and the above-named office may not condition treatment on my signing this authorization.

_____   _____
Signature of Patient or Authorized Representative   Date Signed

_____
Relationship to Patient
*The authorization will expire one year from the date signed
Medical processing fee: MEDICAL RECORDS 10 PAGES OR FEWER CAN BE FAXED AT NO CHARGE, 11 PAGES OR MORE WILL BE MAILED AT A $10 FEE PER CHILD and PARENTS CAN PICK UP RECORDS FOR FREE.

Credit Card #_____ exp_____cvc_____

Amount $_____ Name on Card_____