



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): _____

Nombre(s) de los paciente(s)

DOB: ____/____/____

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 informacion de Psiquiatria, 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 informacion a revelar:

- € Entire medical record/expediente medico completo
- € Immunization Record/Imunizaciones
- € Only dates: from/desde ____/____/____ to/hasta ____/____/____
- € Other/otro: _____

THE PURPOSE OF THIS REQUEST IS:

El proposito 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 OPCION:

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?

International Pediatrics

Kensington

10901 CONNECTICUT AVE
SUITE 100

KENSINGTON, MD 20895

FAX: 240-669-3014

Gaithersburg

501 N. FREDERICK AVE
SUITE 212

GAITHERSBURG, MD

FAX: 240-669-3014