TLC PEDIATRICS L.L.C. and ASSOCIATES
4357 NORTHVIEW DRIVE
BOWIE, MD 20716
Phone (301) 352-6515
Fax (301) 352-6516

Patient Information:

Print name: _____ Date of Birth: _____

Address_____ Phone #_____

Please release my healthcare information from:

Name of Facility/Provider:

_____

Address: _____

City/State/Zip _____

Phone/Fax Number: _____

Please send my healthcare information to:

Name of designated recipient:

_____

Address: _____

City/State/Zip _____

Phone/Fax Number: _____

Information to be released **Format:** Paper Electronic (CD)

- □ Complete Medical Record
- □ Records from_____ to _____only
- □ The most recent 2 years of pertinent information (chart notes, labs, ultrasounds and special tests)
- □ Immunization Record
- □ Other (Specify): _____
- □ Billing Records from _____to _____

Purpose of Request:

- □ Continuing Care
- □ Personal use
- □ Workman's Comp.
- □ Disability Determination
- □ Other (Specify): _____

Fees for Copying Medical Records

The following fees will apply:
A base preparation fee of $22.88 (**waived for patient requests**).
A charge of $0.76 cents per page, and the actual cost of postage $ (fee determined once documents are weighed)
These fees must be paid before your records can be released.

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 the disclosure of this health 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.

Patient Authorization

I understand that I may be charged the fees shown above for the copying of my medical records. I authorize *TLC Pediatrics,LLC* to release my medical records (including medical information related to the diagnosis or treatment for HIV testing, drug and alcohol, or a psychiatric condition) as specified above. This request will remain in effect for one year from the date the Authorization is signed.
Contact TLC Pediatrics' office manager with questions regarding your request.

Printed Name: _____ Relation to Patient: _____

Signature: _____ Date: _____
(Patient, Parent, Guardian*, Authorized Representative*)
* Must provide documentation to prove authority to sign on behalf of the patient)