**KIDDIE HEALTH PEDIATRICS**
1232 Race Rd, Suite 202, Baltimore, Maryland 21237
Phone: 410-687-0808 | Fax: 410-687-0070

# AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

**Patient Name:** ________________________________ | **Date of Birth:** ___________________

**Provider / Practice Sending Records**

| Name of Provider/Practice | Phone Number | Fax Number |
|---|---|---|
| ____________________________ | ____________ | __________ |

**Records to be Released:**

☐ **FAX:** Immunization Records
☐ **EMAIL or MAIL:** Last Wellness Visit
☐ Recent Labs
☐ All Important Medical Records

**Release To:**
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## Special Authorization (Initial One):

| Type of Record | YES ☐ (Initials) | NO ☐ (Initials) |
|---|---|---|
| STD / HIV Records | __________ | __________ |
| Drug / Alcohol Treatment | __________ | __________ |
| Mental Health Treatment | __________ | __________ |

**Purpose:** ☐ Transfer of Care

I understand that I may revoke this authorization in writing at any time.

**Signature of Parent/Guardian:** _______________________________

**Printed Name:** ______________________________DATE _______________