# Gold Pediatrics LLC

15005 Shady Grove Rd., Suite 450
Rockville, MD 20850
Errol K. Douglas, M.D.,F.A.A.P.
(301)517-9710 Phone (301)517-9713 Fax

**Patient Request for Medical Records Form**
**Authorization to Disclose/Release Protected Health Information**

Patient(s) Name: _____ Date(s) of Birth: _____

_____ _____

_____ _____

Patient(s) Address: _____ Acct.(s)/Chart(s): _____

Street Address _____

_____

_____ Phone Number cell: _____

City, State, Zip Code home: _____

For Record Release: By signing this authorization, I authorize Gold Pediatrics LLC named above to disclose (PHI) protected health information about myself and/or child(ren) to the entity listed below. It is my right to revoke this authorization at any time, in writing to the address listed below provided the requested information has not yet been disclosed/released.

_____
New Provider/Specialist

_____
Street Address

_____
City, State, Zip Code

_____
Phone# Fax#

Information to be Released:

| | | |
|---|---|---|
| [ ]All Records | [ ]Labs | [ ]Dates of Service:_____ |
| [ ]X-ray(s) | [ ]Growth Charts | [ ]Immunizations |
| [ ]Pre Op. | [ ]Most Recent WCC | [ ]Other:_____ |

Reason for Record Release:

| | | |
|---|---|---|
| [ ]Provider Change | [ ]Moved | [ ]Insurance Change |
| [ ]Other | | |

_____ _____ _____
Signature of Patient or Legal Guardian Printed Name of Patient of Legal Guardian Date

**This authorization permits: Gold Pediatrics LLC at 15005 Shady Grove Road Suite 450 Rockville, MD 20850 to use information requested from and disclosed by the above listed Provider/Specialist. I understand that this authorization is valid for one year from the date on which it was signed.**

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FOR INTERNAL PURPOSES ONLY: NAME & TITLE OF PERSON SUBMITTING REQUEST FOR RECORDS:_____

□FAXED □EMAILED □MAILED

TO:_____ ON:_____