MARYLAND CHILDREN HEALTH CENTER

Mary A. Ogunsanya, MD, FAAP, Board Certified
Infants, Children & Adolescents

12150 Annapolis Rd, Suite 208
Glenn Dale, MD 20769
Phone: 301-218-0398
Fax: 301-218-0040

6130 Oxon Hill Rd, Suite 202
Oxon Hill, MD 20745
Phone: 301-567 1767
Fax: 301-839-6128

Patient Medical Records Release Form

Patient Name: ______________________ DOB: ______________

Address: ______________________

Phone Number: ______________ Treatment dates from ______________ to ______________

I hereby authorize:

____

____

____

To release copies of my medical records to: **Maryland Children Health Center**

☐ 12150 Annapolis Rd, Suite 208
Glen Dale, MD 20769

☐ 6130 Oxon Hill Rd, Suite 202
Oxon Hill, MD 20745

I Authorize release of information of the following portion of my medical records:

_____ Entire medical record

_____ Immunization Only

_____ Labs & X-rays

_____ Patient is here

I understand that this information shall be in effect for 180 days following the date of signature. However, I understand that this authorization may be revoked at any time by giving an oral or written notice to the medical office. A photocopy of this authorization shall constitute a valid authorization. I understand that once my medical records have been released, the medical office cannot retrieve them and has no control over the use of the released copies.

I hereby release MARYLAND CHILDREN HEALTH CENTER from any and all liability which may arise as a result of my authorized release of records.

Should my case require review by governing agency or another medical profession actively involved in my care to make a final determination, it is with my consent that a copy of those records will be submitted to the agency or medical profession for this review.

Parent/Legal Guardian Signature: ______________________ Date ______________

Relationship to the patient: ______________________

18+ Patient Consent Authorization Form

I ______________________________ authorize **Maryland Children Health Center** to disclose information regarding

1. My entire chart ______
2. Lab work results ONLY _______
3. None of the above ______

To: ______________________________ Relationship: ______________

______________________________________ Date: ____/____/____
Patient Signature (18 yrs or older)

Cell Phone Number (or best # to reach me at) __________________________
____ Please notify me first of any LAB RESULTS.

Authorization for Parental PORTAL Access

I hereby give **Maryland Children Health Center** permission to give my parent access to my PROTECTED HEALTH INFORMATION on my PORTAL account.

Parent name gaining access: ______________________________________

______________________________________ Date: ____/____/____
Patient Signature

These authorizations are valid until otherwise rescinded by myself.

Preferred Contact Methods: (circle one for each method): Message and Data Rates may apply, check with your Carrier)

Medical Issues: Cell Phone / Text to Cell / Email

Appointment Reminders: Cell Phone / Text to Cell / Email

Recall Notices: Cell Phone / Text to Cell / Email

Billing Statements: Mail Address / Text to Cell / Email

General Practice Notices: Cell Phone / Text to Cell / Email

Patient Portal Access: No/Yes If yes, use

Email: ____