Pediatric Partners, LLC
604 Hoagie Drive
Bel Air, Maryland 21014
(410) 893-4844
(410) 893-4927 – Fax

AUTHORIZATION FOR RELEASE OF OUR MEDICAL RECORDS:

I authorize Pediatric Partners, LLC to disclose the health information for:

Patient Name: ________________________________ **Date of Birth:** ______________________

Address: ____

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Patient Phone: __________________________ **Cell Phone:** __________________________

The health information should be sent to or will be picked up by:

Name: ____

Address: ____

____

Phone: ______________________________ **Fax:** _________________________________

Please include the following items: _______ Complete Record

_______ Sick Visits _______ Well Visits _______ Immunizations _______ Growth Charts
_______ Laboratory _______ Radiology _______ Consults _______ Operative
_______ Hospitalizations
_______ Other: (Please list specific items): ____

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_______ **Mail Records** _______ **Pick Up Records** _______ **Fax Records**

I understand there is a $20.00 charge for copying and handling my request. I understand that all fees will be in compliance with applicable State guidelines. By signing this authorization, I agree to pay these fees at the time of this request.

I hereby authorize you to release the protected health information on the patient listed above for continuing medical care. I reserve the right to revoke this authorization in writing at any time. Furthermore, I understand that this Protected Health Information may be re-disclosed by the recipient and thus, is no longer protected under privacy rules.

______________________________________ ______________________ **Date:** __________

Patient Signature (age 18 & over) **Relationship to Patient**
Guardian Signature if patient is a minor.

If you are the healthcare agent, legal guardian (other than parents) or court appointed Personal Representative of the deceased; please attach proof of your authority to act on behalf of the patient.