PEDIATRIC PARTNERS, LLC
9011 CHEVROLET DRIVE – SUITES 7 & 8
ELLICOTT CITY, MARYLAND 21042
(410) 465-4111
(410) 465-4124 - 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: _____

_____

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): _____
_____

_____**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.