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

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Information

Patient Name: ______________________________

Patient Address: ______________________________

____

Patient Date of Birth: ______________________________

Phone: ______________________________

Request Release From:

Doctor: ______________________________

Address: ______________________________

____

Phone: ______________________________

I hereby authorize you to release to Pediatric Partners, LLC, a copy of my medical records to be used 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.

____
Patient Signature if age 18 or older
Guardian Signature if patient is minor.

____
Date

____
Print Name

Please include the following items:

- ______ Sick Visits
- ______ Well Child Visits
- ______ Hospitalizations
- ______ Immunizations
- ______ Growth Charts
- ______ Laboratory
- ______ Operative Reports
- ______ Radiology Reports
- ______ Consultation Reports
- ______ Other ______________

Remarks: ______________________________

This authorization will expire on: ______________.