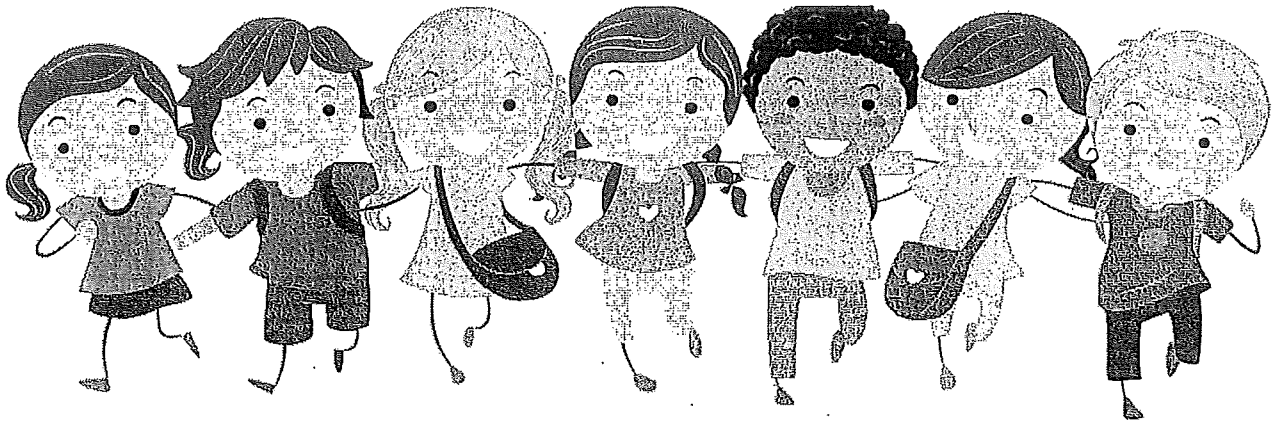

PEDIATRIC PARTNERS, LLC

8600 LASALLE ROAD, SUITE 105

TOWSON, MD 21286

Phone: 410-823-5232 Fax: 410-296-0257

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Information:

Patient's Name:_____ Date of Birth:_____

Address:_____

Phone Number:_____

Release From:

Doctor/Practice:_____

Address:_____

Phone Number:_____ Fax:_____

Please include the following items: ____ Complete Record

____Sick Visits ____Well Visits ____Immunizations ____Growth Charts

____Pathology ____Radiology ____Consults ____Operative

____Hospitalizations ____Other:_____

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 o 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. I understand this authorization will expire one year after the date of signature.

_____ _____ _____

SIGNATURE OF GUARDIAN OR PATIENT (18 & OVER) RELATIONSHIP TO PATIENT DATE