

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: \_\_\_\_\_  
\_\_\_\_\_

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.

\_\_\_\_\_  
Patient Signature (age 18 & over)  
Guardian Signature if patient is a minor.

\_\_\_\_\_  
Relationship to Patient      Date: \_\_\_\_\_

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.