

PEDIATRIC PARTNERS, LLC
4C NORTH AVENUE – SUITE 400
BEL AIR, MARYLAND 21014
(410) 638-0239
(410) 638-0257 – Fax

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Information

Request Release From:

Patient Name: _____

Doctor: _____

Patient Address: _____

Address: _____

Patient Date of Birth: _____

Phone: _____

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: _____.