OFFICE USE ONLY:

Faxed: _____Time: _____Initials: _____

2nd attempt Faxed: _____Time: _____ Initials: _____

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

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS FROM OLD DOCTOR TO PEDIATRIC PARTNERS, LLC

Patient Information

Patient Name: _____

Patient Address: _____

_____

Patient Date of Birth: _____

Phone: _____

Request Release From old doctor

Doctor: _____

Address: _____

_____

Phone: _____

Fax #: _____

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 Date
Guardian Signature if patient is minor.

_____

Print Name

Please include the following items:

____ ***LAST*** well note ____ ***LAST*** sick note
____ Immunization (please send 1st if remaining information will be pending)
____ Growth Chart ____ Radiology ____ labs: lead/cbc/hgb/pku #1 & 2

Remarks: _____

This authorization will expire on: _____.