PEDIATRIC PARTNERS, LLC
KEVIN SEYMOUR, M.D.
690 POOLE RD
WESTMINSTER, MD 21157
PHONE # 410-848-1019
FAX # 410-751-9891

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 fee/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.

______________________________ ______________________ **Date:** __________

Patient Signature (age 18 & over) **Relationship to Patient**
Guardian Signature if patient is a minor.

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.