Pediatric Partners, LLC
Kevin Seymour, MD
690 Poole Road
Westminster, MD 21157
410-876-7616 or 410-848-1019
Fax 410-751-9891

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
FROM PREVIOUS PHYSICIAN TO PEDIATRIC PARTNERS, LLC

Patient Information

Patient Name _____

Patient Address _____

_____

Patient Date of Birth _____

Phone _____

Request Release from Previous Doctor

Doctor _____

Address _____

_____

Phone _____

Fax number _____

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
Parent/Guardian signature if a minor

Date

_____

Print Name

Please include the following items:

____ ALL Medical records ____ LAST Well note ___ LAST Sick note

____ Immunizations (please send first if remaining information will be pending)

____ Growth Chart ____ Radiology ____ Labs: lead/cbc/hgb/pku 1 & 2

Remarks: _____

This authorization will expire on _____