the Pediatric Group

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO THE PEDIATRIC GROUP

DATE OF REQUEST: ______________________________

PATIENT NAME: ______________________________

PATIENT DATE OF BIRTH: ______________________________

PERIOD COVERED: ______________________________

I, the undersigned, request that a copy of your complete records regarding the above-named patient, including, but not limited to, histories, physical examinations, diagnoses, progress notes, test results, x-ray findings, prognosis and disabilities (temporary and/or permanent) regarding the care given by:

Physician/ Facility Name: ______________________________

Street Address: ______________________________

City, State, Zip: ______________________________

Phone: ______________________________

Fax: ______________________________

Please Mail or Fax To:

The Pediatric Group

2772 Rutland Road

Davidsonville, MD 21035

Phone: 410-721-2273

Fax: 443-332-4401

I agree that the Pediatric Group is not responsible for any action or adverse consequences related to the release of this information.

______________________________ ______________________________

Signature *Relationship to Patient*

____

Print Name

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