AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO THE

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: _____

Please Mail or Fax To:

The Pediatric Group

2772 Rutland Road

Davidsonville, MD 21035

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