P.O. Box 6429
Annapolis, MD 21401
410.721.2273
www.pediatricgroup.com

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, prognoses 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
PO Box 6429
Annapolis, MD 21401
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