the Pediatric Group

AUTHORIZATION TO RELEASE MEDICAL RECORDS

INSTRUCTIONS: If you are a patient requesting a copy of your own records, a processing fee of $.76 per page will be applied. In addition, for requests from another healthcare provider, law firm or other third party, a processing fee of $22.88 will be applied. We will notify you of the total amount due upon receipt and processing. Requests will be processed within 7 business days or receipt of payment. Thank you.

Mail: **The Pediatric Group**
2225 Defense Hwy., Suite E
Crofton, MD 21114

Fax: **443-332-4401**

As a patient/ parent or guardian of the patient(s) listed below, I request to receive the following medical records:

□ Immunization Record only (free of charge)
□ Most recent lab results
□ By mail to: _____
□ By fax to: _____
□ Most recent physical exam
□ Most recent x-ray report

Patient Name	Date of Birth

□ I authorize the Pediatric Group to release medical records of the above patient(s) to:

Physician/ Practice: _____

Street Address: _____ City, State, Zip: _____

Phone No.: _____

Please indicate medical records to be transferred:

□ Basic medical records (Immunization record, growth charts, last sick and well visits)
□ Complete medical record (Immunization records, growth charts, all sick and well visits, all lab reports, and x-rays ordered by the Pediatric Group). The Medical Record Staff will contact you regarding any applicable processing fees.

Please indicate the primary reason for transfer of medical records to facilitate the process:

□ Moving out of area □ Flexibility/ Availability of office locations □ New Insurance

□ Dissatisfaction Reason: _____

□ Other Reason: _____

_____ _____
Signature of Patient or Representative Telephone Number

_____ _____ _____
Print Name Relationship to Patient Date