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 14 business days of receipt of payment. Thank you.

Mail: **The Pediatric Group**
P.O. Box 6429
Annapolis, MD 21401

Fax: 443-332-4401

As the 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 physical examination
□ Most recent lab results
□ Most recent x-ray report

□ By mail to : _____

□ By fax to: _____

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 in order 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