Clarksburg Pediatrics

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Clarksburg, MD 20871
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Fax: 301-528-8282

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Montgomery Village MD 20886
Phone: 301-869-6461
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REQUEST FOR MEDICAL RECORDS

Name of Person Requesting Records: _____

Relationship to Patient(s): _____ Contact Phone #: _____

Patient's Name: _____ Date of Birth: _____

Patient's Name: _____ Date of Birth: _____

Patient's Name: _____ Date of Birth: _____

I, hereby authorize Clarksburg Pediatrics, LLC

__ to release copies of medical records to: **__ to obtain copies of medical records from:**

_____
Name/Organization

_____
Address

_____ _____
Phone Fax

Reason for release of records:

_____

Information to be released:

__ Complete medical record

__ Immunization Record

__ Labs

__ Other: _____

I hereby authorize the release of medical records for the patient(s) above. This authorization will expire 1 year from the date of signature below. I understand that I may revoke this authorization by submitting written notice of revocation to Clarksburg Pediatrics, LLC.

_____ _____
Signature of Parent/Guardian or Patient (if 18 years or older) Date