



11717 Old National Pike, Suite 8  
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## Request for Medical Records

James P. Lee, M.D. \* Megan Richardson, FNP-C \* Adrienne Harmel, CPNP

Patient Name: _____	Date of Birth: _____
Patient Name: _____	Date of Birth: _____
Patient Name: _____	Date of Birth: _____
Patient Name: _____	Date of Birth: _____
Patient Name: _____	Date of Birth: _____

Parent/Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_

Reason for Release of Records: \_\_\_\_\_  
 Information to be released:  Medical Record  Immunization Record  Other: \_\_\_\_\_

**Records to be released from:**

**Records to be sent to:**

<p>_____ <i>Name of Physician/Agency</i></p> <p>_____ <i>Address</i></p> <p>_____ <i>Address</i></p> <p>_____ <i>Phone Number</i>                      <i>Fax Number</i></p>	<p><b>Frederick County Pediatrics</b>          11717 Old National Pike, Suite 8          New Market, MD 21774          Phone: 301.882.7489 Fax: 301.882.7520</p>
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*I hereby authorize **Frederick County Pediatrics** to obtain health information for the above named patient(s). This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation.*

\_\_\_\_\_  
*Signature of Parent/Guardian:*

\_\_\_\_\_  
*Date:*