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Request for Medical Records

James P. Lee, M.D. * Jennifer Burns, 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>Frederick County Pediatrics 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: