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Authorization to Release Medical Records

James P. Lee, M.D. * Jennifer Burns, M.D. * Amy Mathew, M.D. * 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 disclosed: ☐ Medical Record ☐Immunization Record ☐Other:_______________________

Records to be released to:

____ ___________________________

Name of Physician, Company/ Agency *Phone Number*

____ ___________________________

Address *Fax Number*

____

City, State, Zip Code

*I hereby authorize **Frederick County Pediatrics** to release 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:*