224 Mayo Road Edgewater, MD 21037

Medical Records From:

Name of Facility:_____

Address:_____

City, State, Zip Code:_____

Phone Number:_____

Fax Number:_____

Medical Records To:

Name of Facility:_____

Address:_____

City, State, Zip Code:_____

Phone Number:_____

Fax Number:_____

Please release medical record information and / or immunization record information for:

Patient Name:_____ DOB:_____

Patient Name:_____ DOB:_____

Patient Name:_____ DOB:_____

I am aware that if the medical record has information regarding substance abuse, psychiatric treatment, or communicable diseases, this information may be released.

What You Want Copied:

Records Required/ Date of Service:_____Complete Record:_____
Immunizations:_____ Other (Please Specify):_____
Purpose of Disclosure:_____
_____

I authorize the release of medical information to another provider/facility as deemed necessary for my treatment or transfer. I further authorize South River Pediatrics to obtain medical information from another provider/ facility as deemed necessary in the course of my treatment. This authorization will expire sixty (60) days from the date of signature. In the State of Maryland, the physician who creates the patient's record is the owner of those medical records. Maryland Law states that photocopies may be released to the patient or parent upon proper written request within a reasonable period of time. I understand there is a $22.88 admission fee if sent to someone other than parent/patient and $.76 per page after that. There will be a postage fee applied if mailed. All fees must be paid upfront before copying can begin.

Patient/Parent/Guardian Signature:_____ **Date:**_____

Telephone Number: (H): _____ (W):_____

Date/Initials Completed: _____ Fee Collected: $_____