

PRIMARY PEDIATRICS
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize:

(name of physician, facility or hospital)

(address)

(city)

(state & zip)

(phone #)

to release the medical records of:

(patient name and date of birth -- printed)

(patient name and date of birth -- printed)

(patient name and date of birth -- printed)

(patient name and date of birth -- printed)

Please mail or fax records along with this form to:

(check one)

Primary Pediatrics
9811 Mallard Dr #109
Laurel, MD 20708
(301) 776-8000
(301) 776-8052 (FAX)

Primary Pediatrics
17001 Science Drive #116
Bowie, MD 20715
(301) 464-2300
(301) 464-9604 (FAX)

Primary Pediatrics
2415 Musgrove Rd #207
Silver Spring, MD 20904
(301) 989-0085
(301) 989-9063 (FAX)

(signature of parent or guardian)

(date)

(name of parent or guardian -- printed)

(address)

(city/state/zip code)

(home phone)

office use only
rec'd by: _____
date: _____
medical records attached?
<input type="checkbox"/> yes <input type="checkbox"/> no