OBTAIN MEDICAL INFORMATION FORM

Patient Name_____ (please print) DOB: _____

I hereby authorize THE PEDIATRIC CENTER, LLC to:

__X___ OBTAIN my medical records from:

_____

(Person/Organization to receive information)

_____

Street Address

_____

City, State and Zip Code

_____

Phone Number Fax Number

PLEASE DO NOT FAX MORE THAN 10 PAGES-PLEASE MAIL IF MORE

Please check below the following information to be obtained:

Complete Medical Record_____
Laboratory Reports_____
Radiology Reports_____
Office Notes_____
OTHER (please specify) _____

Immunization Record_____
Procedure Reports_____
Consultation Reports_____

I understand that the medical records to be released may contain protected health information(PHI) related to Hepatitis, HIV status, AIDS, STDS, Alcohol or drug use, or Mental Health Services, and I hereby authorize the release of this information. All information released will be handled confidentially. This authorization for disclosure is specific for this request only and is valid for one year from the date of this authorization. I may withdrawal this authorization at any time except to the extent that action has been taken in response thereon.

_____ _____ _____

Signature of Patient or Parent/Guardian Date Signed Contact Phone Number

5900 Waterloo Road ♦ Suite 110 ♦ Columbia MD 21045 ♦ 443-451-1600 ♦ Fax 443-451-1619