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Towson, Maryland 21286
Phone No. 410-494-1369
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750 Main Street Suite 203
Reisterstown, Maryland 21136
Phone No. 410-526-7993
Fax No. 410-526-5144

MEDICAL RECORD RELEASE

Patient Authorization for Use and Disclosure of Protected Health Information

Date of Request: _____ To: _____ (Physician at Main Street Pediatrics)

Authorization Valid Until- Date: _____ (not to exceed 1 year)

Patient Name: _____ Date of Birth: _____

_____ Date of Birth: _____

_____ Date of Birth: _____

_____ Date of Birth: _____

Requested By: _____ Relationship to Patient: _____

By signing this I authorize MAIN STREET PEDIATRICS to release the Medical Records
(Protected Health Information on the above named child(ren). This Protected Health Information
is to be sent to:

Complete Name and Address of Physician or Clinic

Patient/ Parent/ Legal Guardian Signature: _____

(Patient if over 18 years old)

Check Below:

Complete Chart (There is a charge for this) Check medical information you want sent:

_____ Records forwarded by previous physicians _____ X-Ray reports

_____ Medical records while under our care _____ Consultations

_____ Hospital administration _____ Laboratory results

_____ ALL OF THE ABOVE

OR

_____ Medication list, immunization record, growth chart and last well visit (there is a charge for this)

_____ Other, please specify what is needed: _____

Primary Physician Signature: _____

Release Completed By: _____ Date Sent: _____