Main Street Pediatrics, LLC
515 Fairmount Avenue
Suite 200
Towson, Maryland 21286

MEDICAL RECORD RELEASE

Date of Request: __________________

To: ____________________________________

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I authorize the release of medical records to:

Main Street Pediatrics, LLC
515 Fairmount Avenue
Suite 200
Towson, Maryland 21286

ATTENTION: Dr.________________

Patient Name: ____________________________________ Date of Birth: ________________

____________________________________ Date of Birth: ________________

____________________________________ Date of Birth: ________________

____________________________________ Date of Birth: ________________

Requested By: ____________________________________ Relationship: _________________

Patient/ Parent/ Legal Guardian Signature: ____
(Patient if over 18 years old)

Home phone number: ____________________ Work phone number: __________________