

TAKOMA PARK PEDIATRICS

7610 Carroll Avenue, Suite 400

Takoma Park, MD 20912

DATE: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____ authorize Takoma Park Pediatrics to release medical information and/or copies of medical records of:

Patient Name: _____ DOB: _____

TO: _____
Name

Address

Reason for Request:

MOVING INSURANCE LAWYER SPECIALIST OTHER

PLEASE CHECK WHICH OF THE FOLLOWING METHODS YOU WOULD LIKE TO RECEIVE YOUR RECORDS:

PICK UP

FAXED TO: () _____

MAILED TO: _____

Your Contact Phone Number: () _____

* Please note that a request for transfer of medical records may take up to 14 working days.