# PEDIATRIC PARTNERS, LLC

# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Request Release from:

Name of Physician/Practice: _____

Address: _____

City: _____ State: _____ Zip: _____

Request Release To:

_____

Address: _____

City: _____ State: _____ Zip:_____

Patient Information

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip:_____

I hearby authorize you to release a copy of my medical records to Pediatric Partners, LLC to be used for continuing medical care. I reserve the right to revoke this authorization in writing at any time. Further, I understand that this Protected Health Information may be re-disclosed by the recipient and thus, no longer protected under privacy rules.

Signature: _____ Date: _____
(Patient signature if age 18 or older)
(Guardian signature if patient is a minor) Phone: _____

Please include the following items:

_____Sick Visits _____Laboratory

_____Well Visits _____Immunizations

_____Hospitalizations _____Growth Charts