10807 Falls Road, Suite 200
Lutherville, MD 21093
410-321-9393
www.mdped.com

Authorization to Release Medical Records

Patient Information	
Patient Name	
Patient DOB	
Patient Address/Phone Number	
MPG Primary Care Physician	
Email	

Reason for Disclosure	Please check one
☐	**Transfer to a new provider** Please provide their name and address if you would like us to send the records to their attention. Name:_____ Address: _____
☐	**Legal Review**
☐	**School/College**
☐	**Other** Please Specify:_____

Information to be Released	Please check one
☐	**Basic Information** Includes: Problem List, Immunization Record, Growth Charts, most recent Physical Exam, most recent Office Note and last laboratory report
☐	**Immunization Record**
☐	**Most Recent Physical**
☐	**Complete Medical Record** I understand that if my/my child's chart includes records prior to 2012, these records are kept offsite. We will not be able to provide these to you electronically and this will cost $0.76 per page. There may also be a delay in record processing due to offsite record retrieval. **Initials:** _____
☐	**Other** Please specify:_____

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Requested Format of Records	Please check one
☐	**Printed** Mailed to the above address (you will be responsible for postage and handling fees) ☐ Pick up in office ☐
☐	**Flash Drive** Pick up in office
☐	**Email** We use an encrypted email to send records securely. However, there is an inherent risk whenever information is sent electronically. **Please initial here that you accept the risk: _____**

Authorization and Signature	
By signing below, I, the undersigned hereby authorize The Maryland Pediatric Group, LLC to release copies of medical records as detailed above. This authorization will expire 1 year from the date of signature. I understand that I may revoke this authorization in writing at any time except to the extent that action on this authorization has already occurred.	
Signature of Parent/Guardian or Patient (if 18 years or older)	
Printed Name/Relationship to patient	
Date	