

VALLEY PEDIATRIC ASSOCIATES, L.L.C.

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Phone: 410-902-7710 • Fax: 410-902-4410

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Information

Name: _____

Address: _____

City: _____

DOB: _____

Social Security #: _____

Request Release from:

Name: _____

Address: _____

City: _____

ZIP CODE: _____

I hereby authorize you to release a copy of my medical records to Valley Pediatric Associates, 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.

Parent Signature

Date

Please include the following items:

_____ Complete Medical Record

_____ Check up and sick visit records

_____ Immunization Record

_____ Growth Charts

_____ Newborn Records

_____ Hospital Discharge Summaries

_____ Consultation Notes

_____ Laboratory Tests

_____ Other

Remarks:

This authorization will expire on _____.

Shari R. Cohen, M.D.

Rona L. Stein, M.D.

Joyce L. Zmuda, M.D.

Last Update 12/22/09