REQUEST FOR RELEASE OF MEDICAL RECORDS

REGARDING PATIENT (NAME):_____

DATE OF BIRTH:_____

To Whom It May Concern:

I hereby request that a copy of my child's medical records be released and forwarded to:

Olney Pediatrics
18111 Prince Philip Drive
Suite 311
Olney, Maryland 20832
Phone: 301-774-4100
Fax: 301-774-7648

Please include a copy of all pertinent laboratory and x-ray findings.

Thank you for your assistance in this matter.

Parent's Signature:_____ Date:_____

Parent's Name (Printed):_____

Parent's contact #:_____

Witness:_____ Date:_____

Please fax immunization records ASAP.
Do NOT fax more than 5 pages, please mail.