LIFEBRIDGE PEDIATRICS AT LUTHERVILLE

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T: 410-583-6800 F: 410-583-5259
E-MAIL: LUTHERVILLEPEDIATRICS@GMAIL.COM

REQUEST FOR RELEASE OF MEDICAL RECORDS

I authorize : _____

DOCTOR OR PRACTICE NAME

_____

ADDRESS

_____

PHONE NUMBER FAX NUMBER

To release the medical records of:

_____

PATIENT NAME PATIENT DATE OF BIRTH

To the office of: LUTHERVILLE PEDIATRICS
1205 YORK ROAD, SUITE 18
LUTHERVILLE. MD 21093

Please send the following:

_____ FULL MEDICAL RECORD

_____ LAST PHYSICAL ONLY

_____ IMMUNIZATION RECORD

_____ GROWTH CHART

_____ PROBLEM LIST

_____ MEDICATION LIST

_____ LAB RESULTS

_____ OTHER

_____

**** I UNDERSTAND THAT BY MAKING THIS REQUEST AND SIGNING BELOW THAT I AM RESPONSIBLE FOR ANY FEES THAT MAY BE ASSOCIATED REGARDING PROCESSING, PRINTING, AND SHIPPING OF THE RECORD IN QUESTION****

_____ _____

SIGNATURE RELATIONSHIP TO PATIENT (SELF, PARENT, GUARDIAN.)

_____

DATE