87 Thomas Johnson Drive, Suite 101
Frederick, MD 21702
Phone: (301) 694-0606 **Fax:** (301) 662-6928

Authorization for Disclosure of Medical Information

To: ____

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Fax Number: ___________________________________

The undersigned hereby authorizes and requests you provide:
FREDERICK PEDIATRIC ASSOCIATES
87 Thomas Johnson Drive, Suite 101
Frederick, MD 21702

With a copy of:

____ Entire Medical Record (Please **Mail** only)

____ Immunization Record **ONLY** - Please Fax upon receipt to **301-662-6928**

____ Specific Information: ____

For the following patient (s):

Patient's Name (s)	Birthdate	Parent's Name (s)

Will pick up ____ Please Mail: ____

This disclosure is valid for redisclosure of medical records that you have received from other providers and/or facilities, so long as those other providers have not specifically prohibited disclosure.

Please contact parent directly if there are any fees or questions in regards to this request. Thank you.

Date: _______________

____
(Parent's Signature)

____
Contact Phone Number