



Jeffrey P. Bernstein, M.D., F.A.A.P.  
 Linda A. Paxton , M.D., F.A.A.P.  
 Robin G. Witkin , M.D., F.A.A.P.  
 Daniel H. Feldman, M.D., F.A.A.P.  
 Aasha L. Parikh , M.D., F.A.A.P.  
 Vi T. Nguyen, M.D., F.A.A.P.  
 Nadira Ramnarain, M.D., F.A.A.P.  
 Website: pacaremd.com

**Medical Records Request for Personal Health Information.**

By signing this authorization, I authorize and request Pediatric and Adolescent Care of Silver Spring, P.A. to copy and transmit medical records and protected health information (PHI). This authorization requests medical information about the following patients:

	Name	Date of Birth
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

A summary of the patient records including immunizations and growth charts will be prepared. **Please allow up to 10 business days for request to be completed.**

The records should be sent to (Please print clearly):

\_\_\_\_\_ Parent / Patient: Name and Address :  
 Best Contact Number: \_\_\_\_\_

\_\_\_\_\_ Another Physician: Name, Address, and Fax Number:  
 Phone Number: \_\_\_\_\_

- I will be transferring out of the Practice.
- I will not be leaving the practice. Please state reason for requesting records and list any specific information needed.

\_\_\_\_\_

\_\_\_\_\_

Signed by: \_\_\_\_\_ Relationship to Patient  
 Signature of Patient (if 18 or older) or Legal Guardian

\_\_\_\_\_ Date of Request  
 Print Name of Patient (if 18 or older) or Legal Guardian

***Fax to (301) 681-4268 or Mail to: 12501 Prosperity Drive Ste 100 •Silver Spring, MD 20904***