PRIVIA MEDICAL GROUP

PEDIATRIC & ADOLESCENT CARE OF SILVER SPRING

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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: _____ _____
Signature of Patient (if 18 or older) or Legal Guardian — Relationship to Patient

_____ _____
Print Name of Patient (if 18 or older) or Legal Guardian — Date of Request

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