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.
Tamara M. Buckley, M.S.N., P.N.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. **There is $15.00 charge (per child) for this summary; available in 10 business days**. Please make payment upon request.

The records should be sent to:

______ Parent / Patient: Name and Address :

______Another Physician: Name and Address:

☐ 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

Revised: 2/11/2016