PEDIATRIC AND ADOLESCENT CARE OF SILVER SPRING, P.A.

PATIENT REQUEST TRANSFER OR COPY OF PROTECTED 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.	_____	_____
5.	_____	_____
6.	_____	_____

A summary of the patient records including immunizations and growth charts will be prepared. **There is $15.00 charge for this summary; available in 10 business days**.

The records should be sent to:

☐ Parent / Patient: Name and Address :

☐ Another Physician: Name and Address:

Reason for request:

_____

_____

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

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