Pavilion Pediatrics at Green Spring Station, P.A.
10755 Falls Road, Suite 260
Lutherville, Maryland 21093
Phone: (410) 583-2955 Fax: (410) 583-2962

Authorization to Release Medical Records/Information

I, _____ hereby authorize _____
Name of Facility/Provider transferring from

_____

to release medical records for Name: _____

Birth Date: _____ Phone: _____

Address: _____

_____

for the purpose of continuation of patient care.

To: **Pavilion Pediatrics at Green Spring Station**
10755 Falls Rd, Suite 260
Lutherville, Maryland 21093

I request the following records to be released: (please check ALL that apply)

_____ ALL records of _____
Name of Facility/Provider transferring from

_____ Records during the time period of _____

_____ Physical Exams _____ Lab Reports _____ Immunization Record _____ Other

By signing below, I affirm that I have the authority to authorize release of the requested records and the use or disclosure of protected health information. I further affirm that there are no claims or orders effective or pending that prohibits, limits, or restricts my ability to make this authorization. I understand that by releasing the records they may no longer be protected by Federal and /or State privacy laws.

_____ _____
Signature Date

_____ _____
Print Name of Signature Relationship to Patient/Authority