

**THE MARYLAND PEDIATRIC GROUP, L.L.C.  
PEDIATRIC CONSULTANTS, P.A.**

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**AUTHORIZATION FORM TO REQUEST MEDICAL RECORDS**

Dear Patient, Parent or Guardian:

We will be happy to forward a copy of the medical record(s) you have requested. The requested medical records will be forwarded within a reasonable time in accordance with State and Federal Regulations. However, to release any medical information that originated from the physician(s) at the Maryland Pediatric Group, L.L.C./Pediatric Consultants, we must have a signed authorization from the person concerned or in the case of a minor child, the parent or guardian. In addition, we will ONLY provide documentation of services rendered at our practice. Any information provided to our practice from a previous provider will not be included. The record release policy for The Maryland Pediatric Group, L.L.C./Pediatric Consultants requires that a separate Authorization Form be completed for each medical record transfer request.

**Patient name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Patient Telephone:** \_\_\_\_\_ **Name of physician:** \_\_\_\_\_

**Current mailing address:** \_\_\_\_\_

**Previous mailing address** (during the time you/your child were a patient in our office, if different from above):  
\_\_\_\_\_

**Name & Address of physician to whom you want the requested medical records transferred to:**  
\_\_\_\_\_  
\_\_\_\_\_

I understand that there is a \$ 20 preparation fee for sending records to another provider or health care facility plus the cost of copying and postage associated with receiving medical records. The processing fee is waived when records are sent to the patient/parent directly. If the record(s) has been inactivated and has been placed into off site storage, there is an additional fee of \$25.00 per child to retrieve the record(s). \_\_\_\_\_ **Parent/Guardian Initials**

I understand that if the party receiving this information is not a health care provider or health plan subject to the federal privacy regulations that the information described above may be re-disclosed and no longer protected by the privacy regulations. \_\_\_\_\_ **Parent/Guardian Initials**

I understand that I may revoke this authorization in writing at any time except to the extent that action on this authorization has not already occurred. This authorization becomes effective \_\_\_\_\_ **(today's date)** and will expire \_\_\_\_\_. **(not to exceed one year)**

Parent/Guardian Signature authorizing release of medical records from The Maryland Pediatric Group, L.L.C./Pediatric Consultants:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Processing fee \_\_\_\_\_  
# of pages copied \_\_\_\_\_ @\$ .73/page  
Postage fee \$ \_\_\_\_\_  
Off site fee \$ \_\_\_\_\_  
**Total Fee charged \$ \_\_\_\_\_**