BRYN MAWR PEDIATRICS
600 Haverford Road
Suite 103
Haverford, PA 19041
610-642-9609 Fax: 610-642-9612

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date: _____

Patient Name (s): _____ DOB: _____

_____ DOB: _____

_____ DOB: _____

I, _____, authorize Bryn Mawr Pediatrics to release medical information to:

Name of provider or facility: _____

Address and phone number: _____

□ Family picked up and will take to facility □ Mailed to facility □ Faxed to facility

Purpose for this request: (check one) □ Transfer of Care □ Moving □ Insurance □ Other

Type of records requested: (check one)

□ Entire medical record/ plus other physician's records
□ Entire medical record/ without other physician records
□ Labs/ X-ray
□ Mental health (includes ADD/ADHD)
□ Other _____

By signing below, I am authorizing Bryn Mawr pediatrics to release my medical records to the above address. I also understand that there is a fee per child to release medical records (fees vary due to size of chart).

Signature of patient or legal guardian _____ Date: _____

Relationship to patient (if requester is not the patient) _____