7500 Hanover Parkway, Suite 203H
Greenbelt, MD 20770

Phone: 301-895-7337
Fax: 855-850-9065
Email: DrMelvil@EdgePediatrics.com

Patient Authorization for release of records TO another physician or healthcare provider.

I _____, _____ of _____ hereby request the
(Name) (Relation to Patient) (Patient's Name)
Release of information from Edge Pediatrics, please send TO:

Name/Facility: _____

Address: _____

_____

Phone Number: _____ Fax Number: _____

Patient Name:_____

Date of Birth:_____

___ Complete Medical Record
___ Immunization Record
___ Laboratory Reports
___ X-ray/Scan Reports

Fees for Copying Medical Records:
A charge of $20. All balances on account including cost of records, must be paid before your records can be released.

Patient Authorization
I authorize Edge Pediatrics to release my medical records as specified above. This request will remain in effect for one year from the date the Authorization is signed.
Contact Edge Pediatrics office manager if you have any questions
Thank You.

_____ _____
Signature Date