



Children's National.

Children's National Pediatricians & Associates Authorization for Release of Medical Information

I hereby authorize and request the release and transfer of my medical records from:

Attention: _____

Address: _____

Phone #: _____

Fax #: _____

For the following patient(s):

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Please release the following records:

- Entire medical record
- Immunization record
- All progress notes
- Last progress note
- Problem list
- Medication list
- Growth chart
- Lab results
- Medical record from _____ to _____
- Consultation notes
- _____
- _____
- _____

To the following selected office:

Office	Address	Phone	Fax
<input type="checkbox"/> Bowie	12200 Annapolis Rd # 320, Glenn Dale, MD 20769	301-218-3700	301-218-3909
<input type="checkbox"/> Capitol Hill	650 Pennsylvania Ave #C-100 SE, Washington, DC 20003	202-833-4543	202-420-7400
<input type="checkbox"/> Clinton	9015 Woodyard Rd #111, Clinton, MD 20735	301-599-0900	301-599-7828
<input type="checkbox"/> Foggy Bottom	2021 K St NW #800, Washington, DC 20006	202-833-4543	202-833-8977
<input type="checkbox"/> Fort Davis	3839½ Alabama Ave SE, Washington, DC 20020	202-582-6800	202-584-1665
<input type="checkbox"/> Gaithersburg	555 Quince Orchard Rd #350, Gaithersburg, MD 20878	301-926-3633	301-948-9884
<input type="checkbox"/> Greenbelt	7701 Greenbelt Rd, Suite 510, Greenbelt, MD 20770	301-220-1200	301-474-5590
<input type="checkbox"/> Laurel	13900 Laurel Lakes Ave #240, Laurel, MD 20707	301-498-1900	301-497-9885
<input type="checkbox"/> Silver Spring	10801 Lockwood Dr #230, Silver Spring, MD 20901	301-593-5566	301-593-3644
<input type="checkbox"/> Upper Marlboro	9692 Pennsylvania Ave, Upper Marlboro, MD 20772	301-599-7300	301-599-0476
<input type="checkbox"/> Waldorf	3450 Old Washington Rd #100, Waldorf, MD 20602	301-645-0300	301-645-4009

I hereby authorize the release and transfer of the records requested above.

Parent/ Guardian Name: _____

Signature of Parent/Guardian: _____

Date: _____

Relationship to Patient: _____

Signature of Patient: _____
(age 18 years or older)

Date: _____

Office Use Only:

Intergy Acct #: _____

Intergy Pt Person #: _____

Request Submitted by: _____