Children's National

Authorization for Release of Medical Information

I hereby authorize and request the release and transfer of my medical record 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
☐	Bowie	12200 Annapolis Rd, Suite 320, Glenn Dale, MD 20769	(301) 218-3700	(301) 218-3909
☐	Capitol Hill	600 Pennsylvania Ave SE, Suite 500, Washington, DC 20003	(202) 833-4543	(202) 420-7400
☐	Clinton	9131 Piscataway Rd, Suite 700, Clinton, MD 20735	(301) 599-0900	(301) 599-7828
☐	Foggy Bottom	2021 K St NW, Suite 800, Washington, DC 20006	(202) 833-4543	(202) 833-8977
☐	Fort Davis	3839½ Alabama Ave SE, Washington, DC 20020	(202) 582-6800	(202) 584-1665
☐	Gaithersburg	555 Quince Orchard Rd, Suite 350, Gaithersburg, MD 20878	(301) 926-3633	(301) 948-9884
☐	Greenbelt	7701 Greenbelt Rd, Suite 510, Greenbelt, MD 20770	(301) 220-1200	(301) 474-5590
☐	Laurel	13900 Laurel Lakes Ave, Suite 240, Laurel, MD 20707	(301) 498-1900	(301) 497-9885
☐	Silver Spring	10801 Lockwood Dr, Suite 230, Silver Spring, MD 20901	(301) 593-5566	(301) 593-3644
☐	Upper Marlboro	9692 Pennsylvania Ave, Upper Marlboro, MD 20772	(301) 599-7300	(301) 599-0476
☐	Waldorf	3450 Old Washington Rd, Suite 100, Waldorf, MD 20602	(301) 645-0300	(301) 645-4009

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

Signature of Parent/Guardian: _____ **Date:** _____

Relationship to Patient: _____

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

Email the completed form to medicalrecords@childrensnational.org.

Office Use Only:
Patient MRN: _____
Request Submitted by: _____

Last Updated October 21, 2025