THH PEDIATRICS
TENDER HEARTS & HANDS

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THH Pediatrics

Authorization for Release of Medical Records

I hereby authorize _____ (Name of Dr.'s office) to transfer all of my children's medical records to:

THH Pediatrics
19735 Germantown Rd.
Suite 200
Germantown, MD 20874

Patient's Name & DOB:

1) _____

2) _____

3) _____

4) _____

Please send ALL medical records
No CD's please!

Purpose or Need for Information:
Transfer of primary care for children

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

Parent/Guardian Phone #: _____