MAPP
MID ATLANTIC PEDIATRIC PARTNERS

THH PEDIATRICS
TENDER HEARTS & HANDS

Request for Release of Medical Records

I hereby authorize _____ (Name of Doctor's Office) to transfer all of my children's medical records to:

THH Pediatrics

19735 Germantown Road, Suite 200

Germantown, Maryland 20874

Name(s) of Patient(s): _____ DOB: _____

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

Please send ALL Medical Records.

No CD's please!

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

Signature of Parent or Legal Guardian: _____ Date: _____

Contact Phone Number: _____