MAPP
MID ATLANTIC PEDIATRIC PARTNERS

THH PEDIATRICS
TENDER HEARTS & HANDS

Request for Release of Medical Records

Date of Request: _____

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

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

I hereby authorize THH Pediatrics, a Division of Mid Atlantic Pediatric Partners (MAPP) to release medical records on the above patient(s).

Signature of Parent or Legal Guardian: _____ Date: _____

Contact Number: _____

Reason for Leaving Practice: _____

How are the records going to be obtained? Circle one: PICK UP MAILED

WE DO NOT FAX RECORDS!

Mailing Address: _____

_____

_____

Records will Include:
- Problem list and pertinent office visits
- Health maintenance sheets
- Growth chart
- Immunization records
- Consult reports
- Pertinent lab work and diagnostic studies

RECORDS NORMALLY TAKE 7-10 BUSINESS DAYS TO COMPLETE