PATIENT REQUEST
OF PROTECTED HEALTH INFORMATION
FROM OTHER PRACTICE

By signing this authorization, I authorize and request

Practice/ Physician's Name: _____

Address: _____

_____

Phone: _____ Fax: _____

To copy and transmit medical records and protected health information request medical information about the following patient(s).

1. **_____ D.O.B_____**
2. **_____ D.O.B_____**
3. **_____ D.O.B_____**
4. **_____ D.O.B_____**
5. **_____ D.O.B_____**

The records should be sent to:

___ Parent/ Patient: Name and Address:

_____

_____

___ TLC Pediatrics L.L.C.
4315 Northview Drive
Bowie, MD 20716
P: 301-352-6515 F: 301-352-6516

Signed By: _____ _____

(Signature of Patient or Legal Guardian) (Relationship)

_____ _____

(Print Name of Patient or Legal Guardian) (Date of Request)