Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me by releasing a copy of my medical records, or a summary or narrative of my protected health information to the facility listed below:

Facility Name: Pediatric Gastroenterology Specialists of Maryland

Address: 6816 Deerpath Rd Suite 205

Elkridge, MD 21075

Phone: (443)539-8338 Fax: (410)796-6111

Patient Name: ____________________________________ Date of Birth: __________________

Address: ____

City, State, Zip: ____

Phone #: ___________________

The information you may release subject to this signed release form is as follows:

*Complete copy of my medical records

*Copy of any radiology reports

Patient Signature: ___________________________ Date: ____________

This form will expire one year from the date of signature