Bear Pediatrics, LLC
Katie Bittner-Cassett, CRNP
1814 Bel Air Rd
Fallston, MD 21047
(O) 443-981-3337, (F) 443-981-3286

Authorization for Release of Medical Records

Patient Information:

Patient Name: _____ Patient DOB: _____

Patient Address: _____

Request Release From:

Doctor/ Office: _____

Address: _____

Phone: _____ Fax: _____

Please include the following items: _____X_____ Complete Record by mail or fax

Please send current vaccine record ASAP by fax to 443-981-3286

I, _____, authorize you to release to Bear Pediatrics, LLC a copy of my medical records to be used for continuing medical care. I reserve the right to revoke this authorization in writing at any time. Furthermore, I understand that this Protected Health Information may be re-disclosed by the recipient and is no longer protected under privacy rules.

_____ _____ _____

Parent or Guardian Signature (< 18 yrs of age) Print Name Date

Patient Signature (> 18 years of age)