Transfer of Records to Lancaster Pediatrics, P.A.

Previous Physician's Name or School's Name

____

Previous Physician's or School's Address: ____

____

Phone Number: _________________________Fax:_____________________________

I authorize my previous medical provider or school listed above to release my Medical Record Information to:

Duniya R. Lancaster, MD, FAAP
Lancaster Pediatrics, P.A.
2850 North Ridge Road, Suite 203
Ellicott City, MD 21043
Phone (410) 480-2803, Fax (410) 480-2806

Patient's Name: _____________________________________ Birth Date: __________ Sex: F/ M

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Patient's Name: _____________________________________ Birth Date: __________ Sex: F/ M

Patient's Name: ______________________________________ Birth Date: __________ Sex: F/ M

Patients' Address: ____

Parent's Name: ___________________________ Parent's Name: __________________________

Information to be released: _____ All Records, _____History & Physical Exams, _____Growth Charts

_____ Specialists' Notes, _____ X-Ray Reports, ______ Lab Reports, _____ Immunization Records

Purpose of Disclosure: _____ Changing Provider/Practice, ______ Other

_______________________________________ _______________________

(Signed by Patient/Parent/Legal Guardian) (Date Signed)

____ (written name/relationship to patients)