# Authorization to Release Patient Information

I, _____ Parents of_____

Hereby authorize _____ to release the following information to:

Clarksburg Pediatrics, LLC

23216 Brewers Tavern Way

Clarksburg, MD 20871

Phone: 301-528-8181

Fax: 301-528-8282

This record request is to include:

___ Entire Medical Record

Or

Other information listed below

_____

_____

_____

Parents/Guardian Signature: _____ Date: _____

Parent/Guardian Print Name: _____

Authorization expired from 1 year from the above date.