COLUMBIA MEDICAL PRACTICE
PEDIATRICS

6220 Old Dobbin Lane
Suite 290
Columbia, MD 20145

Phone: 410-964-6300
Fax: 410-964-6227
Email: pediatrics@cmpractice.com

Pediatrics Record Request

PATIENT INFORMATION

Please use a separate form for each patient

Full Name _____

Date of Birth ____ /____ /____

REQUESTED FORMS

Immunization Record or School Medication Forms	☐ Next Day - $5	☐ Same Day - $10
Health Inventory, Sports Physical, or Camp/Scouts Forms *These include immunization records*	☐ 3-5 Days - $15	☐ Next Day - $25
FMLA, Extensive Disability, or Home & Hospital Forms	☐ 5-7 Days - $25	☐ 24 - 48 Hours - $25

PREFERRED METHOD OF RETURN

☐ Email _____

☐ FAX ( ) - _____ ATTN: _____

☐ Mail _____

☐ Pick up from office

I hereby authorize Columbia Medical Practice to release the requested PHI for the patient listed above. I certify I have the legal right to request these records.

Printed Name _____ Signature _____ Date _____

Relation to patient _____ Best Phone _____

OFFICE USE ONLY

Patient MRN _____ Last Physical ____ /____ /____

Provider _____ **FORM FEE** ☐ Paid ____ /____ /____

☐ Due at pickup ☐ No Charge