CHILDREN FIRST, LLC
PEDIATRICS & ADOLESCENT MEDICINE
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CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth_____
Address: _____
Phone Number: _____Treatment dates from: _____ to _____

I hereby authorize: Children First, LLC
1300 Caraway Court Suite #106
Largo, MD 20774

To release copies of my medical records to: _____
_____

I authorize release of information of the following portions of my medical record:

_____ Entire Medical record
_____ Immunizations only
_____ Labs & X-rays
_____ Patient Is Here

I understand that this information shall be in effect for 180 days following the date of signature. However, I understand that this authorization may be revoked at any time by giving oral or written notice to the medical office. A photocopy of this authorization shall constitute a valid authorization. I understand that once my medical records have been released, the medical office cannot retrieve them and has no control over the use of the already released copies.

I hereby release CHILDREN FIRST, LLC from any and all liability which may arise as a result of my authorized release of records.

Should my case require review by a governing agency or another medical profession actively involved in my care to make a final determination, it is with my consent that a copy of these records will be submitted to the agency or medical profession for this review.

Parent / Legal Guardian Signature_____Date:_____
Relationship to Patient:_____

NOTICE: The information has been disclosed to you from records whose confidentiality has been protected by federal and state law. You are prohibited from making further disclosures of such information without specific consent of to whom such information pertains or as otherwise permitted by state law. A general authorization is not sufficient for this purpose.