Bucci Lancer Pediatrics

7600 Osler Drive, Suite 310

Towson, MD 21204

Phone: 410-296-2300 Fax: 410-296-3444

Record Release Date: _____

I hereby authorize Bucci Lancer Pediatrics to release all medical records pertaining to:

Name: _____

Date of Birth: _____

This includes all immunizations, and any information including diagnosis and records of any treatment or examination rendered under the care of Dr.Bucci and Dr.Lancer. I am aware that all records will be released to my secure portal account and there will not be a records release charge.

I am also aware that there is a $.76 a page charge for the preparation of all medical records that cannot be sent to the portal account and is payable in check or card only. This fee must be paid prior to records being released and cannot be billed.

Signature: _____

Printed Name: _____

Relationship to the patient: _____

In order to better serve our patients, please complete the following information. Once completed, records will be sent to the portal within 10-14 business days.

E-mail Address: _____

Reason for Record release: _____

Please rate your experience with our practice 1-5, 1 being very dissatisfied & 5 being very satisfied.

Experience with Dr.Bucci: _____

Experience with Dr.Lancer: _____

Experience with Melissa Hays, CRNP _____

Experience with front staff: _____

Experience with back staff: _____

Experience with billing/administration: _____

Comments:

_____

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