Bucci Lancer Pediatrics
7600 Osler Drive, Suite 310
Towson, MD 21204
Phone: 410-296-2300 Fax: 410-296-3444

PATIENTS NAME(S): ____

DATE OF BIRTH: ____

I hereby authorize Dr. ____

to release all medical records pertaining to the patient(s) listed above.

This includes all immunizations and any information including the diagnosis and records of any treatment or examination rendered under the care of your medical practice.

I would like these records mailed or faxed to the following doctor's office:

Bucci Lancer Pediatrics

Jeffries Bucci, M.D. / Melissa Lancer, M.D. / Melissa Hays, C.R.N.P.

7600 Osler Drive, Suite 310 Towson, Maryland 21204

Parent or Guardian Signature: ____

Date: ___________________________