Authorization for Release of Medical Record

Patient's Name: _____Date of Birth: _____
Address: _____
City, State, Zip: _____

I request and authorize (Former Doctor):
Name: _____
Address: _____
_____
Phone: _____
Fax: _____

To release healthcare information of the patient named above and send copies

TO:
Cinco West Pediatrics
9006 S. Fry Road, Suite D
Katy, TX 77494
Phone: 281-665-3013
Fax: 832-913-8163

This request and authorization applies to:
____History & Physical Exam
____Immunization Records
____Complete Medical Records
Other: _____

For the Purpose of:
____Insurance change
____Moving to a new area
____Transfer to another Pediatrician (Reason)
Other: _____

(This consent and authorization includes, for the period indicated, those care and treatment records designated, pertaining to: physical illness; emotional/mental illness; AIDS/HIV test results, diagnosis, treatment or related information (if any); and/or alcohol and drug use.)

Parent or Guardian Signature:
_____Date: _____