PEDIATRIC MEDICINE, PA

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Authorization for Release of Medical Records

Patient Name: _____
Date of Birth: ____/____/_____
Address: _____
_____
_____

I, the undersigned, hereby authorize you to release complete medical records of the above named patient.

Information to be released from:
Doctor/Clinic: _____
Address: _____
_____
_____
Tel: (____)_____
Fax: (____)_____

Please send the requested medical records to:

Pediatric Medicine, P.A.
7922 Ewing Halsell, Suite 440
San Antonio, TX 78229-3726
Tel: (210) 614-2500 Fax: (210)614-2755

I understand that medical records are confidential and cannot be disclosed without written authorization except as otherwise provided by law. I understand I may revoke this authorization at any time except to the extent that action has been taken in reliance on this authorization.Unless otherwise revoked, this authorization has no expiration date.

Signature: _____ Date:____/____/_____

Relationship to Patient*: _____
Parent of a minor, legal guardian, or representative of the estate only. For guardian or representative, the court order appointing him/her must accompany this form.