Medical Record Release Authorization

Release records to My Pediatrician, PLLC

Physician/Facility Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone number: _____ Fax number: _____

I hereby authorize the above named physician/facility to release the following information:

- ☐ Complete medical record (including growth charts and immunizations)
- ☐ Immunizations only
- ☐ Physician notes
- ☐ Other: _____

To: Dr _____ at My Pediatrician, PLLC

412 Village Drive Suite 400

Murphy, Texas 75094

Phone: 972-325-2188 Fax: 972-535-4107

HIV/AIDS: I consent to the release of HIV/AIDS test results and other related results and information regarding HIV/AIDS as it pertains to the health of my child.

Initials: _____ Date: _____/_____/_____

Patient's name: _____ Date of Birth: _____/_____/_____

I understand that I can revoke my consent at any time prior to the release of records by delivering a written, signed and dated notice of my wish to My Pediatrician, PLLC. I can refuse to disclose some or all of my records, but if I do so, it could result in improper diagnosis or treatment, denial of coverage of a claim for health benefits, or other adverse consequences.

Parent/Guardian's name: _____ Relationship to patient: _____

Signature: _____ Date: _____/_____/_____