



Authorization For Release of Medical Records

To Previous Physician / Practice / Hospital:

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Please release the complete medical records of my child/children to:

Comprehensive Pediatric Care

2379 Gus Thomasson Rd. Ste 200

Mesquite, TX 75150

P: 972-686-6400

F: 972-686-6391

bookings@dallaspeds.com

| Name of child | Date of Birth |
|---------------|---------------|
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"I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

- o COMPLETE medical record: every single page in my medical record.
- o BRIEF medical record (as circled) : Newborn nursery physician discharge summary, Last history and physical, Growth charts, Immunization record, Specialist consult notes, Lab results, Imaging reports, Inpatient reports, ER reports

Signature of Parent/Guardian Authorizing Release:

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Relationship to child/children:

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Date:

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