Comprehensive Pediatric Care
Dallas Office
1151 N. Buckner Blvd. Ste 203 Dallas, TX 75218
P: 214-324-4221 F: 214-324-3705

Mesquite Office
2379 Gus Thomasson Rd. Ste 200 Mesquite, TX 75150
P: 972-686-6400 F: 972-686-6391

Authorization to Release Medical Records (Consentimiento Para Mandar Expediente)

Name of Patient (Nombre del patiente): _____DOB: _____

Home#: _____Cell#_____Email: _____

Parents Names: _____

PATIENT INFORMATION IS NEEDED FOR: PLEASE SELECT ONE OPTION:

- Transferring to another doctor
- Specialist consultation
- Personal Use
- School
- Insurance
- Legal Purposes
- Social Security/Disability
- Other:

If transferring to another doctor, please provide reason for transferring: _____

_____

DATE (s) OF TREATMENT (s):_____

SELECT THE INFORMATION TO BE RELEASED:

□ Complete Medical Record □ Progress Notes □ Lab Reports □ Behavioral Health □ Consultation Report □ Immunization records □ Radiology Reports □ Emergency Room Record □ Operative reports □ Billing □ Other _____

FORMAT REQUESTED FOR INFORMATION TO BE PROVIDED:

□ Paper □ Electronic media* (requires 5 business days)

METHOD OF DELIVERY (CIRCLE ONE): PICK UP MAIL FAX (only to doctor's office)

RELEASE RECORDS TO: Name: _____

Address: _____

Phone #: _____Fax #: _____

I, the parent/guardian understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. **I understand I may be charged a retrieval/processing fee and for copies of my medical records according to Texas Hospital Licensing law.**

Signature of Patient or authorized Representative: _____

Printed Name _____Relationship to Patient _____