West Plano Pediatrics, P.A.

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Medical Records Release Form

Date: ____________________

I hereby authorize the release of a **summary** of the medical records on the children listed below:

NAME: ____ Date of Birth: ______________________

NAME: ____ Date of Birth: ______________________

NAME: ____ Date of Birth: ______________________

NAME: ____ Date of Birth: ______________________

NAME: ____ Date of Birth: ______________________

Please release the **summary** information about my child(ren) as specified:

____ Progress Notes ____ Well Child Exam Notes ____ Immunization Record

____ Lab Results ____ X-Ray Reports

____ Other (Specify) ____

____ I do not want the following parts of my child's record released: ______________________

____

Release my child(ren) records to the following person(s)/entity:

Name: ____

Address: ____

City, State, Zip ____

Phone # ________________________________

Parent's address:

____

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____

Phone # _______________________________

I UNDERSTAND THAT ONLY MEDICAL DOCUMENTATION ORIGINATING IN THE OFFICE WILL BE COPIED. RECORDS FROM AN OUTSIDE FACILITY ARE NOT THE PROPERTY OF THIS OFFICE AND WILL NOT BE DUPLICATED.

Parent's or Legal Guardian Signature: ____

Printed Name: ____

OPTIONAL

I understand and agree that I am requesting copies of the medical records in lieu of the standard summary and that I will be financially responsible for the following fees associated with my request: copying fees and postage related to the production of my child(ren)'s information. I understand that the charge for this service is $25.00 for the first 20 pages and .50 cents for each additional page plus postage (if applicable). If affidavit is required the fee is $15. *These fees are set by the Texas State Board of Medical Examiners as published in the Texas Register. Payment is due prior to the release of the medical record copies.

Parent's or Legal Guardian Signature: ____

Printed Name: ____

POS* Reorder # 0822000