West Plano Pediatrics
6020 W. Parker Road, Suite 310
Plano, TX 75093
Ph (972) 608-0774 Fax (972) 608-0595

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: _____

NAME: _____ Date of Birth: _____

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

_____Well Child Exams _____Sick Visits _____Immunization Record

_____Lab Results _____X-Ray Reports _____Coorespondence

Release records **FROM**:

Name:_____

Street: _____

City/State/Zip: _____

Phone: _____

Release records **TO**:

Name: _____

Street: _____

City/State/Zip: _____

Phone: _____

I understand that only medical documentation originating at West Plano Pediatrics will be summarized/copied. Records from an outside facility will not be duplicated. A request for medical records from a chart held in storage that requires an overnight delivery will cost $40.00 per chart.

Legal Guardian Signature: _____

Printed Name: _____

********** ALTERNATIVE CHOICE **********

I understand and agree that I am requesting a copy of the medical records in lieu of the standard summary, and I will be financially responsible for the following fees associated with my request: handling, copying, and postage related to the production of my child(ren)'s information. I understand that the charge for this service is $25 for the first 20 pages and 0.50 cents for each additional page. If an affidavit is required, the fee is $15. These fees are set by the Texas State Board of Medical Examiners. Payment is due prior to release of the medical record copy.

Legal Guardian Signature: _____

Printed Name: _____