

# West Plano Pediatrics, P.A.

6020 W. Parker Road, Suite 310  
Plano, Texas 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: \_\_\_\_\_

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

\_\_\_\_ Well Child Exams      \_\_\_\_ Sick Visits      \_\_\_\_ Immunization Record  
\_\_\_\_ Lab Results      \_\_\_\_ X-Ray Reports      \_\_\_\_ Correspondence

Release records **FROM:**

Name: \_\_\_\_\_

Street: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Fax: \_\_\_\_\_

Release records **TO:**

Name: \_\_\_\_\_

Street: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Fax: \_\_\_\_\_

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.

Parent's or Legal Guardian Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Please check reasons for records request

Transferring care to a new doctor

Personal records (I understand that requests of medical records for my personal records will incur a charge outlined in the section below)

Other reason (please specify): \_\_\_\_\_

\*\*\*\*\*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 the release of the medical record copy.

Parent's or Legal Guardian Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_