West Plano Pediatrics, P.A.

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Plano, Texas 75093
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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: _____

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: _____