Medical Records Release Form

In accordance with state law and regulatory agency requirements, the health record is the property of **Caring for Kids Pediatrics, PA**. By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person or entity listed below.

I hereby authorize the release of information from:

Physician Name:

Office Name:

Address:

City/State/Zip:

Phone #:

Fax#:

To:

Caring for Kids Pediatrics, PA

343 West Houston Street, Suite 302

San Antonio Texas, 78205

(210) 877-5600 ofc, (210) 877-5601 fax

Patient Information:

Patient Name: **Date of Birth:**

Address/City/State/Zip:

Phone #:

Information to be released:

Please provide items checked below.

____Complete Medical Record	**____Problem List**	**____Consultations**
____Progress Note	**____X-ray Reports**	**____Immunizations**
____Lab Reports	**____History and Physical**	**____Mental Health Record**
____Medication List	**Other:____**	

Signature of Parent, Guardian, or Patient's Legal Representative **Date**

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.