MEDICAL RECORDS RELEASE FORM

This form authorizes recipient to provide a copy, summary, or narrative of my child's medical records or otherwise release
Confidential information.

☐ Complete record
☐ Records of care for the following dates _____ to _____
☐ Records concerning the following conditions: _____
☐ Other, please specify: _____

Patient Name: _____ Date of Birth: _____

Please send my records to:

Memorial City Pediatrics
915 Gessner Suite 985
Houston, Texas 77024
Office (713) 461 91 00
Fax (713) 461 01 76

Records to be released from:

Physician Name: _____ Phone: _____ Fax: _____
Complete address: _____

(This consent and authorization includes, for the period indicated, those care and treatment records designated, pertaining to: physical illness; emotional/mental illness; AIDS/HIV test results, diagnosis, treatment or related information (if any); and/or alcohol and drug use.)

Parent or Guardian Signature: _____ Date: _____

* I understand that Memorial City Pediatrics, may not condition my treatment on whether I sign this authorization unless specified above. I can inspect or copy me protected heath information to be used or disclosed. I authorize Memorial City Pediatrics to use and disclose the protected health information specified above.

* I understand that information used or disclosed pursuant to this authorization may be subject to redisdosure by the recipient nd may no longer be protected by federal HIPAA privacy regulations.

* I understand that I may revoke this authorization at any time except id the extent that action has been taken in reliance on it. This authorization will expire ninety (90) days from the date of my signature.