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
713-461-9100 Office
713-461-0176 Fax

Records to be released from:

Physician Name: __________________Phone: __________Fax:_______
Complete address: ____

The reason or purpose for this release of information request is as follows:
____
____

PROHIBITION ON REDISCLOSURE: This information is being disclosed from records whose confidentiality is protected by state and federal laws. These laws prohibit any further re-disclosure without the specific consent of the patient or the patient's legal representative.

Parent or Guardian Signature: ___________________________________

Date: ________Drivers License or Social Security Number____________