

**West Plano Pediatrics, P.A.**

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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: \_\_\_\_\_

NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

\_\_\_\_ Progress Notes      \_\_\_\_ Well Child Exam Notes      \_\_\_\_ Immunization Record

\_\_\_\_ Lab Results      \_\_\_\_ X-Ray Reports

\_\_\_\_ Other (Specify) \_\_\_\_\_

\_\_\_\_ I do not want the following parts of my child's record released: \_\_\_\_\_

Release my child(ren) records to the following person(s)/entity:

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

Address: \_\_\_\_\_

City,State,Zip \_\_\_\_\_

**I UNDERSTAND THAT ONLY MEDICAL DOCUMENTATION ORIGINATING IN THE OFFICE WILL BE COPIED. RECORDS FROM AN OUTSIDE FACILITY ARE NOT THE PROPERTY OF THIS OFFICE AND WILL NOT BE DUPLICATED.**

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

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

\*\*\*\*\*OPTIONAL\*\*\*\*\*

I understand and agree that I am requesting copies of the medical records in lieu of the standard summary and that I will be financially responsible for the following fees associated with my request: copying fees and postage related to the production of my child(ren)'s information. I understand that the charge for this service is \$25.00 for the first 20 pages and .15 cents for each additional page plus postage (if applicable). \*These fees are set by the Texas State Board of Medical Examiners as published in the Texas Register. Payment is due prior to the release of the medical record copies.

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

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