WINDHAVEN PEDIATRICS
6300 W. PARKER RD STE 324
PLANO, TX 75093

Authorization for Medical Records Release

Patient Information:

_____ Name

_____ Date of Birth

_____ Home Address

_____ Home Phone#

_____ City,State,Zip Code

_____ Work Phone#

Information Released From:

_____ Name of Clinic/Physician

_____ Street Address

_____ City, State , Zip Code

_____ Phone Number(area code)

_____ Fax Number(area code)

Information Released To:

_____ Name of Clinic/Physician

_____ Street Address

_____ City, State, Zip Code

_____ Phone Number(area code)

_____ Fax Number(area code)

Type/Extent of Records To Be Disclosed: (Check One)
(Please note that a fee may be required with this service)

_____ Records pertaining to:_____
(Specific dates or condition)

____Entire Patient Record

Purpose or Need for Disclosure: (check one)

____Personal
____Consult/Specialist
____Change of Insurance
____Moving
____Changing physicians
____Other_____

I hereby authorize release of my medical records. I understand that this release is valid for 90 days from the date of signature and that I may revoke this authorization in writing. I agree that any release made prior to this revocation will be made in compliance with this authorization.

_____ Parent/Guardian Signature

_____ Date