Pediatric Health Partners, PLLC

Authorization to Release Patient Medical Information

I hereby authorize the release of Medical Records, excluding protected, as follows:

- Chart Notes/Medical Summary
- Immunization Records
- Growth Charts
- Laboratory and/or X Ray reports
- Specialist Summaries
- Other:___________________________

Records to be released from:

Name: ______________________________ Street Address: ______________________________

City: ________________________________ State: __________________ Zip: _______________

Phone: ______________________________ Fax: _______________________________________

Records to be released for:

Child's Name: _____________________________ Date of Birth: ___________________________

Child's Name: _____________________________ Date of Birth: ___________________________

Child's Name: _____________________________ Date of Birth: ___________________________

Child's Name: _____________________________ Date of Birth: ___________________________

****If record is more than 20 pages, please fax immunizations only and mail remaining record. Thank you.**

Please send records to:

Pediatric Health Partners, PLLC
4335 Windsor Centre Trail, Suite 130
Flower Mound, TX 75028
Phpflowermound@gmail.com
Office (972) 355-7900 Fax (972) 355-7922

Authorization to Release Medical Information:

____ ____
Name (please print) of Parent/Guardian Phone Number

____ ____________________ _____________
Signature of Parent/Guardian Relationship to Patient Date