Pediatric HealthCare Associates, P.A.

Mom Tested • Kid Approved • Since 1992

Authorization to Release Confidential Medical Information

I hereby request that my medical records be released to:

Facility: **Pediatric Healthcare Associates, P.A**.
Address: **3701 Eldorado Parkway Suite A**
City: **McKinney** State: **TX, 75070**
Phone: **972-548-7888** Fax: **972-562-1170** **(mail if records are over 20 pages)**

My records are being transferred from:

Facility:_____

Address:_____

City:_____ State: _____

Phone:_____ Fax:_____

Reason for request of records: _____

___Entire Health History ___Test Results ___Growth Chart & Immunization Records

___Other:_____

As the guardian of the patient named below, I give permission to release all medical, mental, and social information to the facility listed. I understand that this information is confidential and will only be used for the benefit of the patient. I further understand that this release is valid for one year or until I revoke the authorization in writing.

Patient Name: _____ Patient DOB: _____

Patient Name: _____ Patient DOB: _____

Patient Name: _____ Patient DOB: _____

Parent Signature:_____ Date:_____

Parent Printed Name:_____