

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS



A Bright Future Pediatrics

2100 Hedgcoxe Road Suite 190
Plano, Texas 75025
(972) 208-8668 Fax (972) 208-3186

Patient Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Phone Number _____ Parent Name _____

I authorize and request that a copy of the following information from my medical record be released as follows:

OBTAIN INFORMATION FROM:

A Bright Future Pediatrics
2100 Hedgcoxe Rd, Suite 190
Plano, TX 75025
Telephone: 972-208-8668
Fax: 972-208-3186

RELEASE INFORMATION TO:

Name _____
Address _____
City _____ State _____ Zip _____
Telephone _____
Fax _____

Purpose of Release (check all that apply): Patient Care Personal Use School Other (Please specify)

Records to be released (check all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Problem List | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> History & Physical |
| <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Well Child Checks | <input type="checkbox"/> X-ray Reports | <input type="checkbox"/> Emergency Room Record |
| <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Other (Please specify) _____ | |

I understand that the information released is for the specific purpose state above and may not be provided in whole or in part to any other agency, organization, or person. I further understand that my medical records from other health care providers will not be released with this routine request. This consent will expire six (6) months after the date of signature.

I understand that my medical record may contain reports, test results and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information that has been written in the record.

I understand that I may revoke this authorization in writing at any time to the extent that A Bright Future Pediatrics has already relied on this authorization. I understand that I may revoke this authorization by providing A Bright Future Pediatrics Release of Information Department a written request for revocation stating my intent to revoke this authorization.

I will not hold A Bright Future Pediatrics liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Signature of Patient or Legal Representative

Date

Relationship to Patient

Witness