**REQUEST FOR RELEASE OF MEDICAL RECORDS**

_____

Physician or Practice Name

_____

Address

_____

Phone Number and Fax Number

I request that my child's complete records or specific information as listed below be released to:
Centennial Pediatrics
5560 Independence Parkway
Frisco, TX 75035
214.389.8801 phone
214.389.8802 fax

_____

Patient's Name and Date of Birth

_____

Parent's Signature and Date

_____

Information Requested

_____

Reason for Request

By signing this form I authorize you to release confidential health information about me or my child.

I understand that I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to the facility receiving the revocation.

If the requestor or receiver is not a health care plan or healthcare provider, the released information may no longer be protected by federal privacy regulations or may be redisclosed.

I have read and authorize the disclosure of the protected health information as stated. I may receive a copy of this form after I have signed it.