# CENTENNIAL PEDIATRICS

## Release of Medical Records

5560 Independence Parkway · Frisco, Texas 75035
214.389.8801 214.389.8802 *fax*

By signing this form, I authorize you to release confidential health information about my child, releasing a copy of my records, or a summary narrative of my protected health information, to the person(s) listed below.

**HIV/AIDS:** I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. **INITIALS_____ DATE _____**

Patient's Name:_____

Patient's DOB: _____

**If you have any appointments scheduled, will you be keeping these? _____**

**Will you continue care with our practice? _____**

**Reason for request: (Required) (Please check all that are applicable)**

_____ Moving Out of State _____ Moving Out of Area

_____ New insurance we are not in-network with
Name of new insurance _____

_____ Has appointment with a Specialist _____Type of Specialist

_____ Other (Please Specify) _____

**Please release my protected health information to the following person(s):**

Name: _____ Street: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

**Patient Signature (or Parent/Guardian): _____**

**_____**Request for Summary (No Charge)

_____Patient Request for Complete Medical Records *$6.50 per Request

**_____**3rd Party Request for Complete Medical Record *$25 for 1st 50 pages, $0.50/page thereafter.

*****Please note, if an affidavit is requested, there will be a $15 fee**
*****If a notarized signature is required, there will be a $10 fee**

**We accept MasterCard or Visa**
**____MC ____Visa Account #:_____ Exp: _____**

**Signature: _____**