A Bright Future Pediatrics

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

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name_____ Date of Birth _____

Patient Name_____ Date of Birth _____

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:

RELEASE INFORMATION FROM:	**RELEASE INFORMATION TO:**
A Bright Future Pediatrics 2100 Hedgcoxe Rd, Suite 190 Plano, Texas 75025 Telephone: 972-208-8668 Fax: 972-208-3186	Name _____ Address _____ City _____ State _____ Zip _____ Telephone _____ Fax _____

****Purpose of Release (please specify)** _____

Records to be released (check all that apply):

_____ Problem List _____ Progress Notes _____ History & Physical
_____ Lab Reports _____ Discharge Summary _____ Operative Reports
_____ Well Child Checks _____ X-ray Reports _____ Emergency Room Record
_____ Immunization Records _____ 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