



Medical Records Release Form

In accordance with state law and regulatory agency requirements, the health record is the property of Pediatric Junction, PA. By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

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

Initial: _____ **Date:** _____

I hereby authorize the release of information

FROM:

Physician Office Name: Pediatric Junction

TO:

Physician Name:

Mailing Address: 211 Railroad St.
Buda, TX 78610

Mailing Address:

Phone #: 512-312-5312

Phone #:

Fax #: 512-312-5313

Fax #:

Patient Information

Patient Name:

Date of Birth:

Patient Name:

Date of Birth:

Patient Name:

Date of Birth:

Information to be released: ABBREVIATED (Recommended records pertinent to ongoing medical care. Includes: shot record, growth charts, and recent visits) **NO CHARGE**

COMPLETE MEDICAL RECORD (\$25 fee applies)

OTHER (specify) _____

This Information is necessary for the following purpose:

Continued Patient Care

Personal Use

Insurance

Attorney/Legal (**\$50 fee applies**)

Other (specify) _____

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

Name of Parent or Legal Guardian

Signature

Contact Phone

Date