1000 N Preston Road
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Prosper, TX 75078
(469) 296 - 8030

www.prosper-pediatrics.com
Email: info@prosper-pediatrics.com
facebook: www.facebook.com/prosper.pediatrics
twitter: @ProsperPedsTX

Date: _____ Patient Date of Birth: _____

Patient Name: _____

I, the undersigned, authorize the release of or request access to the information specified below from the medical record(s) of the above named patient, which is called "Protected Health Information" under a federal health privacy law, as described below:

Please release the following:

___All Medical Records

___Newborn Records Name of Hospital: _____

___Shot Records Only

___Other _____

Send Records From:

Name:

Address:

Telephone:

Fax:

Send Records To:

Prosper Pediatrics
1000 N Preston Road
Suite 20
Prosper, TX 75078

Fax: (888) 851 – 4582
Phone: (469) 296 - 8030
Email: info@prosper-pediatrics.com
Website: www.prosper-pediatrics.com

I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I may revoke this authorization at any time by notifying Prosper Pediatrics in writing. However, if I choose to do so, I understand that my revocation will not affect any action taken by Prosper Pediatrics before receiving my revocation. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in the health plan, or eligibility for benefits.

_____ _____
Signature of Parent or Legal Representative Date

_____ _____
Printed Name of Parent or Legal Representative Relationship to Patient