Patient Name: _____Date of Birth:_____

I, the undersign, 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 Record Only ____Other Request _____

Send Records From:

Dr. or Practice _____

Address _____

Telephone _____

Fax _____

Send Records to:

Prosper Pediatrics

1000 N. Preston Rd #20, Prosper TX 75078

469-296-8030

Fax 888-851-4582

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 many 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 Guardian

Date

_____

Printed Name of Parent or Guardian

_____

Relationship to Patient

PLEASE MAIL IF OVER 20 PAGES, DON’T FAX- THANK YOU