

CORRIDOR PRIMARY CARE PEDIATRICS
601B Leah Ave
San Marcos, Texas 78666
PHONE: (512) 392-1700 FAX: (512) 396-8743
REQUEST FOR RELEASE OF MEDICAL RECORDS

Patients Name: _____ DOB: _____

I understand that my/my child's medical records are confidential and cannot be disclosed without my written authorization, except otherwise provided for by law. I hereby voluntarily authorize the health information regarding the above named person to be exchanged between

From: _____ To: _____

Address: _____ Address: _____

City/State/Zip: _____ City/State/Zip: _____

The specific purpose(s) for this disclosure is/are: _____ Phone: _____

() My personal Use _____ Fax: _____

() Sharing with other Healthcare provider

() Other (Specify) _____

() I want () do not want you to include information pertaining to the diagnosis and /or treatment of HIV testing, AIDS, psychiatric illness, and alcohol or chemical abuse or dependency if any.

Specific Information to be released: (Please check all that apply)

___ Complete Medical Record ___ Immunization record only ___ Lab/X-ray

___ History & Physicals ___ Progress note ___ D/C Summary

___ Other _____

* I understand that I may revoke this authorization at any time by notifying the office in writing.

* I understand this authorization expires 180 days from the date signed unless otherwise revoked.

* I understand that once the above information is disclosed it may be re disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

* I understand that a photocopy or facsimile of this authorization is as valid as the original.

Date

Signature of patient, parent or authorized guardian

Print Name