

FORT WORTH PEDIATRICS

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Fort Worth TX 76104
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[] 1533 Merrimac Circle
Fort Worth TX 76107
(817) 336 - 4040
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[] 6401 Harris Parkway, Suite 100
Fort Worth TX 76132
(817) 346 - 2525
(817) 294 - 1692 fax

CONSENT FOR MEDICAL RECORDS RELEASE

I hereby authorize _____ to release information
from the medical record of:

Patient Name: _____ Address: _____
Date of Birth: _____
Social Security# : _____

Period of care from _____ through _____
INFORMATION TO BE RELEASED: _____ Copy of Complete Medical Record

EXCLUSIONS:

- ___ Excluding information relating to testing, diagnosis, and/or treatment of HIV (the AIDS Virus), or
other sexually transmitted diseases.
___ Excluding mental health information (including mental or emotional conditions or disorders,
alcohol and/or drug abuse).

INCLUSIONS (Only this information needed)

- | | |
|---------------------------|---|
| a. ___ Laboratory Results | f. ___ Psychological Reports |
| b. ___ X-Rays | g. ___ Therapy Reports |
| c. ___ EKG Reports | h. ___ Obstetrical Records |
| d. ___ EEG Reports | i. ___ Immunization Records |
| e. ___ Operative Reports | j. ___ Most Recent History and Physical |

OTHER: _____

RELEASE INFORMATION TO: _____
AT THE FOLLOWING ADDRESS: _____

PURPOSE OF RELEASE: ___ Medical Care ___ Insurance Purposes ___ Attorney
___ OTHER: _____

I understand that this release can be REVOKED at any time except to the extent that release made in
good faith has already occurred in reliance on this consent. If revocation is not received, this
authorization will be considered valid for 90 days.

_____, it's employees, officers and attending physicians are released from legal
responsibility or liability for the release of the above information to the extent indicated and authorized
herein.

Parent, Guardian, or Authorized Representative Signature

Date

Relationship to Patient

There is a minimum \$25.00 copy fee for medical records. Please allow 7 to 10 business days to process.