

A Bright Future Pediatrics

7211 Preston Road Suite T 3700 Plano, Texas 75024 (972) 208-8668 Fax (972) 208-3186

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Phone Number _____ Parent Name _____

I authorize and request that a copy of the following information from my medical record be released as follows:

RELEASE INFORMATION FROM:

A Bright Future Pediatrics

7211 Preston Rd, Suite T3700

Plano, Tx 75024

Main 972-208-8668

Fax 972- 208-3186

RELEASE INFORMATION TO:

Name _____

Address _____

City _____ State _____ Zip _____

Telephone _____

Fax _____

****Purpose of Release (please specify)** _____

Records to be released (check all that apply):

Problem List Progress Notes History & Physical
 Lab Reports Discharge Summary Operative Reports
 Well Child Checks X-ray Reports Emergency Room Record
 Immunization Records other (Please specify) _____

I understand that the information released is for the specific purpose state above and may not be provided in whole or in part to any other agency, organization, or person. I further understand that my medical records from other health care providers will not be released with this routine request. This consent will expire six (6) months after the date of signature.

I understand that my medical record may contain reports, test results and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information that has been written in the record.

I understand that I may revoke this authorization in writing at any time to the extent that A Bright Future Pediatrics has already relied on this authorization. I understand that I may revoke this authorization by providing A Bright Future Pediatrics Release of Information Department a written request for revocation stating my intent to revoke this authorization.

I will not hold A Bright Future Pediatrics liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Signature of Patient or Legal Representative

Date

Relationship to Patient