# Request for Release of Medical Records

(Please ask for additional forms if more than one Physician/Practice)

_____

Physician or Practice Name

_____

Address

_____

Phone Number and Fax Number

**I request that my child's complete records or specific information as listed below be released to:**

**Eastside Children's Clinic**
**311 N. Allen Drive**
**Allen, TX. 75013**
**Phone: 972-372-0444**
**Fax: 833-427-1174**

**Patient Name:** _____ **DOB:** ____/_____/_____

**Patient Name:** _____ **DOB:** ____/_____/_____

**Patient Name:** _____ **DOB:** ____/_____/_____

**Patient Name:** _____ **DOB:** ____/_____/_____

Please send all medical records, including immunization records.

By signing this form, I authorize you to release confidential health information about me or my child. I understand that I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to the facility receiving the revocation. If the requestor or receiver is not a health care plan or healthcare provider, the released information may no longer be protected by federal privacy regulations or may be redisclosed. I have read and authorize the disclosure of the protected health information as stated. I may receive a copy of this form after I have signed it.

**Parent Signature:** _____

**Date:**_____