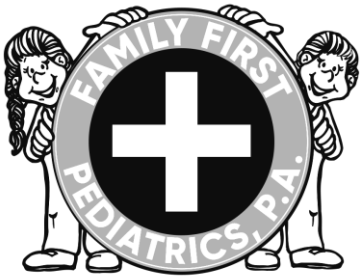
18603 Champion Forest Dr.
Spring, Texas 77379
281-374-8882



Tad Shirley, MD, FAAP
Danielle Lalanne, CPNP-PC

Authorization to Release Medical Records

I authorize the release of medical records for:

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

From: _____ Office Phone: _____

Fax Number: _____

To: _____ Office Phone: _____

Fax Number: _____

Information to be released:

_____ Immunization Record _____ Growth Charts _____ Current Well Child Exam

_____ Hospitalization Summaries _____ Consultant Letters

_____ Labs, X-rays _____ ADHD Records

*** PLEASE MAIL TO THE ABOVE ADDRESS IF RECORDS EXCEED 25 PAGES ***

I understand that this Authorization is valid for 180 days unless I revoke it in writing sooner. I understand the records disclosed become a part of my child's new medical record and may be subsequently disclosed.

Signed: _____ Date: _____
Parent or Legal Guardian

Family First
PEDIATRICS, P.A.
We put families first!