Medical Release Form

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____

City: _____ Zip Code: _____

Please choose release request:

____Full Record ____Immunization Record Only

INFORMATION REQUESTED FROM (CLINIC NAME)

Name: _____

Address: _____ City: _____ State: _____

Phone: (_____) _____ Fax: (_____) _____

SEND INFORMATION TO

Name: **Kidsville Pediatrics**

Mansfield	Phone:	682-341-3910	Fax:	682-400-1288
Southlake	Phone:	682-345-8010	Fax:	682-345-5051
McKinney East (Virginia Pkwy)	Phone:	469-885-9400	Fax:	469-886-1944
McKinney West (Coit Rd)	Phone:	682-868-1020	Fax:	682-219-0556

I, _____(Name), hereby grant permission for you to release confidential health information about me, or my child, by releasing a copy of my medical record, or a summary of my protected health information, to **Kidsville Pediatrics PLLC**.

_____ _____
Printed Name Date

_____ _____
Signature Date