Pediatric Junction, PA

Keeping children's health on the right track!

Medical Records Release Form

In accordance with state law and regulatory agency requirements, the health record is the property of Pediatric Junction, PA. By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records.

Initial: _____ **Date:** _____

I hereby authorize the release of information

FROM:	**TO:**
Physician Office Name: Pediatric Junction	Physician Name:
Mailing Address: 211 Railroad St. Buda, TX 78610	Mailing Address:
Phone #: 512-312-5312	Phone #:
Fax #: 512-312-5313	Fax #:

Patient Information

Patient Name:	Date of Birth:
Patient Name:	Date of Birth:
Patient Name:	Date of Birth:

Information to be released:

_____ ABBREVIATED (Recommended records pertinent to ongoing medical care. Includes: shot record, growth charts, and recent visits) NO CHARGE

_____ COMPLETE MEDICAL RECORD ($25 fee applies)

_____ OTHER (specify) _____

This Information is necessary for the following purpose:

___ Continued Patient Care
___ Personal Use
___ Insurance
___ Attorney/Legal ($50 fee applies)
___ Other (specify) _____

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

Name of Parent or Legal Guardian	Signature	Contact Phone	Date