

## Pearland Pediatrics

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### Authorization for release of medical information

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
(First, Middle, Last)

Requester's Name and Phone #: \_\_\_\_\_

#### I hereby authorize and request copies of medical records from:

\_\_\_\_\_  
(Name of Company/Agency/Facility/Person) (Phone#)

\_\_\_\_\_  
(Street Address, City, State, Zip) (Fax#)

#### Information to be released to:

\_\_\_\_\_  
(Name of Company/Agency/Facility/Person) (Phone#)

\_\_\_\_\_  
(Street Address, City, State, Zip) (Fax#)

#### Check Information to be requested:

- Entire Record
- Immunization Records
- TB Skin Test
- Lab Tests
- X-Ray Reports
- Physical Exams
- Discharge Reports
- Billing Records
- Other(specify): \_\_\_\_\_

#### Reason for Request:

- Change of Doctor
- Continuation of Care
- Personal Records
- Attorney/Legal
- Insurance
- Consultation
- Other(specify): \_\_\_\_\_

#### I would like this information to be:

- Mailed
- Picked Up
- Faxed (Only shot records can be faxed)

I understand this information is confidential and there shall be no further disclosure without the written authorization of the patient and his/her legal guardian. Multiple requests may necessitate a copying fee of \$25.00. Please be aware that by state law we have 14 days in which to comply with your request. (Shot records can usually be faxed the same day.)

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

Office use only:

Date Request Complete \_\_\_\_\_ Initials \_\_\_\_\_