Pearland Pediatrics, P.A.

Jason Decker, M.D., F.A.A.P. Brad Onhaizer, M.D., F.A.A.P. Jennifer Dr. Gray, M.D., F.A.A.P.
Deborah L.Gant, M.D., F.A.A.P. Shannon O. Stroope, M.D., F.A.A.P. Heather Hummel, M.D., F.A.A.P.
Carolyn Wagner, M.D., F.A.A.P. Christine Palacios, M.D., F.A.A.P., Jeannie Huyhn M.D.
2017 Broadway, Pearland, TX 77581 (P) 281-485-9990 (F) 281-485-9469
www.pearlandpediatrics.com

Authorization for release of medical information

Patient Name: _____ DOB:_____

Address: _____ 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:

Pearland Pediatrics
2017 Broadway Street, Pearland, Texas 77581
Phone: 281-485-9990 Fax: 281-485-9469

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 for this information to be:

☐ Mailed

☐ Pick up

☐ 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