HERITAGE
PEDIATRICS, PLLC

Phone: 210 - 804 - 2301
FAX: 210 - 805 - 9523

Medical Records Release Form

Patient Name:_____Date of Birth:_____

Person requesting records:_____Relationship:_____

Release my protected health information

FROM:	TO:
Name: _____	Name: _____
Street:_____	Street:_____
City: _____	City: _____
State:_____Zip:_____	State:_____Zip:_____
Fax #:_____	Fax #:_____

I DO_____I do NOT_____ give permission for these records to be faxed to the above entity.

Dates of service to be released:

- ☐ Any and all dates of service
- ☐ Other: _____

Records to be released:

- ☐ Growth Charts
- ☐ Vaccine History
- ☐ Pertinent Lab Results
- ☐ Pertinent Medical Records

Purpose of disclosure:

- ☐ Referral or Continuity of Care
- ☐ Transfer of care
- ☐ Shot Record
- ☐ Other:_____

By signing this form, I have the parental authority to authorize access, and give permission for Heritage Pediatrics to release any and all confidential health information about above child, by releasing a copy of their medical records, or a summary or narrative of their protected health information, to the person(s) or entity listed above.

**Please do not send more than 15 pages via fax. If you have more than 15 pages, please mail them to the above address.

Signature Date