Starside Pediatrics
1518 Legacy Dr. Suite 110 Frisco, TX 75034
Newborn Child and Adolescent Medicine
Diplomats of the American Board of Pediatrics

Phone: 214-494-4212 Fax: 214-494-4214

Date of request _____

Patient (s) Legal Name _____ DOB _____

_____ DOB _____

Home Address _____ Telephone _____

City, State, Zip _____

I hereby authorize the release of medical records from ☐ or to: ☐

Name: _____ Fax Number _____

Address: _____ Telephone _____

City,State,Zip: _____

Purpose for Request: _____ : _____

Type of records requested:

Copy of the records: ☐ Entire Chart ☐ Vaccines ☐ History & Physical ☐ Emergency Documents

☐ Laboratory ☐ Radiology Reports ☐ Medication Record ☐ Progress Notes

☐ Growth Charts ☐ Billing ☐ Other: All records from previous doctors

Please note that records may be either faxed, mailed or be given in electronic format.

I understand that I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to Starside Pediatrics receiving revocation. Further details may be found in the Notice of Privacy Practices.

If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.

Copy fees/charges will comply with the Texas State Board of Examiners, Chapter 165 and all other laws and regulations applicable to release of information. Medical Records: $25.00. Immunization records $5.00

I understand that treatment and payment are not a condition of signing this authorization. I may receive a copy of this form after I have signed it.

I have read the above and authorize the disclosure of the protected health information as stated.

Date _____ Signature of Patient/Patient Representative _____

Relationship to Patient(s) _____