



Pediatric Healthcare Associates, P.A.

Authorization to Release Confidential Medical Information

I hereby request that my medical records be released to:

Facility: **PEDIATRIC HEALTHCARE ASSOCIATES**
Address: **3701 El Dorado Parkway, Ste. A McKinney, TX 75070**
Phone: **(972) 548-7888** Fax: **(972) 562-1170**

My records are being transferred from:

Facility: _____
Address: _____
Phone: _____ Fax: _____

Reason for leaving the practice: _____

entire health history test results phone calls
 growth charts shot records

As the guardian of the patient below, I give permission to release all medical, mental and social information to the facility listed. I understand that this information is confidential and will only be used for the benefit of the patient. I further understand that this release is valid for one year or until I revoke the authorization in writing.

Patient's Name & DOB: _____

Parent Signature: _____

Date: _____

