HEALING CARE
pediatrics

Request for Release of Health Records Form

Patient Name: _____ Date of Birth: _____

I as the parent or legal representative of the patient, request that the following protected health information (medical records) be released for treatment purposes.

PLEASE only send Vaccine Record & Problem List unless specified otherwise.

Please put your initials on the appropriate line below.

_____ VACCINE RECORDS & PROBLEMS LIST (DO NOT send Full Medical Records).

Release the medical record of the patient named above from the following medical provider:

Name of Physician or Medical Practice: _____

Address/City/State/Zip: _____

Phone: _____ Fax: _____

Please send the records to: Dr. Khanum Saleha / Healing Care Pediatrics.

Address: 12530 Lebanon Rd, Suite 203, Frisco, TX 75035 Ph: (972) 200-7862 Fax: (972) 200-7949

I understand that federal laws and regulations do not require an authorization for release of protected health information for treatment purposes. This form is to provide a formalized written manner of communication for requesting protected health information from one healthcare provider to another. This health request will expire in 180 days unless otherwise revoked.

_____ _____ _____

[*Name of the authorized representative to patient*] [*Phone*] [*Relationship to patient]*

_____ _____

[*Signature of authorized representative to patient*] [*Date*]

I understand that the records released may include information related to Human Immunodeficiency Virus (HIV) Infection or Acquired Immunodeficiency Syndrome and/or treatment for or history of drug or alcohol abuse, mental, behavioral or psychiatric care. I understand this authorization is voluntary & I may refuse to sign it.