Robbins Pediatrics Medical Release Form

By signing this form, I authorize you to release confidential health information about the patient named below, by releasing a copy of the medical records, or a summary or narrative of the protected health information, to the person(s) or entity listed below.

Patient Name:_______________________________________ DOB:_________________________

Name of entity/ doctor's office from whom records are requested:

____

Release the protected health information to the following person(s)/entity:

Robbins Pediatrics
1508 Santa Fe Drive, Suite 102
Weatherford, TX 76086
Ph: 817-596-3500 Fax: 817-596-3524

The reasons or purposes for this release of information are as follows:

Patient signature (or parent, guardian or legal representative):

____ Date: _________