AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

This authorization to release information is being requested of you to comply with the terms of the Health Insurance Portability and Accountability Act of 1996.

Patient's Name:_____ Birthdate:_____

Patient's Name:_____ Birthdate:_____

I hereby authorize: Name/ Address/ and Contact Numbers

Legacy Pediatrics

7103 South Peek Road
Unit E500
Richmond
Texas 77407

Phone number : 3466206850
Fax number : 18775691910

To release information to:

_____

_____

_____

Number:_____ Fax:_____

This release limits disclosure to: (Check one) [] All records [] Immunization record only [] Test results

This information is required for: (Please Check one)

[ ] Treatment
[ ] Personal Use
[ ] Continuation of Care
[ ] Legal Use

Print Name of parent/Guardian:_____
(Or patient, if over age of 18)

Signature:_____

Contact Number:_____ **Date:**_____