Mark D. Towns, M.D. • Louis A. Hunke, M.D. • Thomas W. Deacon, M.D. • Jacquelynn A. Longshaw, M.D.

Pediatrics Southwest

REQUEST FOR MEDICAL RECORDS TO PEDSW

(For Specialists or Previous Physicians)

Please complete the following information:

Patient Name: _____ DOB: _____

_____ _____

_____ _____

Requesting from Facility/Dr.: _____

Address: _____

City, State, Zip Code: _____

Phone/Fax No: _____

I authorize the custodian of my child/children's medical records to disclose/release the following information for the treatment period from to (check all that apply):

- ☐ Visit Records
- ☐ Immunization Records
- ☐ Growth Charts
- ☐ Other _____

Please release this protected health information to: _____
Physician's Name

Purpose for this request:

- ☐ Family Move
- ☐ Switching Doctors
- ☐ Insurance Change
- ☐ Other _____

Pediatrics Southwest
2828 Duke of Gloucester, Suite 106
DeSoto, Texas 75115
Office No. (972) 298-3888
Fax No. (972) 296-0838

This authorization will automatically expire in six (6) months from the date on my request.
I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent that action has already been taken to release this information. I have a right to inspect copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. The above named person/institution will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

*****PLEASE MAIL ANY RECORDS OVER 25 PAGES*****

Signature of parent

Printed name of parent Date: _____

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