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

Pediatrics Southwest

REQUEST FOR MEDICAL RECORDS TO PEDSW

(For Specialists or Previous Physicians)

Please complete the following information:

Patient Name: _____ DOB _____
_____ DOB _____
_____ 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

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

Purpose for this request:
_____ Family Move
_____ Switching Doctors
_____ Insurance Change
_____ Other _____

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 a 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 Date:

_____
Printed name of parent