Request for Release of Medical Records

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Physician / Practice / Hospital Name

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Street Address *City, State* *Zip Code*

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Office Phone Number *Office Fax Number*

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Patient Name *Date of Birth*

Complete chart

Immunization records and growth charts

Please release the requested medical records to TLC Pediatrics for the above noted patient. This authorization shall be in force and effect for one year at which time this authorization expires.
I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

TLC Pediatrics, PA

1105 N. Central Expressway North, Ste. 250 Allen, TX 75013
Office: 972-747-KIDS (5437) Fax: 972-747-5497

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Parent/Guardian Signature *Date*