



REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: _____
(Physician or Facility Name)

Address _____ City _____ St _____ Zip _____

Phone Number _____ Fax Number _____

I hereby request that my child's complete records or specific information as listed below be released to:

All About Children Pediatrics
Todd Burton, M.D., Kelley Smith, M.D., Jodi Lemeshev, M.D.,
Holly Whitesell, PA-C
2217 Eldorado Parkway
McKinney, TX 75070
972.542.1444 Fax: 972-542-6967

Patient's Name _____ Patient's Date of Birth _____

Parent's Signature _____ Today's Date _____

Information Requested _____

I understand that I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to the facility receiving the revocation. Further details may be found in the Notice of Privacy Practices.

If the requestor or receiver is not a health care plan or healthcare provider, the released information may no longer be protected by federal privacy regulations or may be redisclosed.

I have read and authorize the disclosure of the protected health information as stated. I may receive a copy of this form after I have signed it.

Please note that the physician or facility you have requested records from have 15 days by law to send us these records.