3604 S. Cooper Street, Suite 120, Arlington, TX 76015

Phone (817) 466-8008, Fax (817) 466-8131

CONSENT FOR MEDICAL RECORDS RELEASE

Patient's Name ____ Birth Date ____________________

Address ____

City/State/Zip ____

I hearby authorize Gold Pediatrics, P.A. to obtain a copy of the specific health information indicated:

____ Complete medical chart

____ Immunization records

____ Growth charts

____ X-ray reports

____ Laboratory results

____ Consults ___________________________

Other ____

Obtain records from:

Gold Pediatrics, P.A.

3604 S. Cooper Street, Suite 120

Arlington, TX 76015

Phone (817) 466-8008 Fax (817) 466-8131

Please release records to:

____

____

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Unless otherwise revoked, this authorization will expire in six months from the date signed. I understand that authorizing the disclosure of this health information is voluntary.

Name ____

Signature ____

Relationship _____________________________________ Date _____________________________________