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 ____ X-ray reports

____ Immunization records ____ Laboratory results

____ Growth charts ____ Consults _____

Other _____

Obtain records from: _____

Address _____

City/State/Zip _____

Phone _____ Fax _____

Please send/fax records to : Gold Pediatrics, P.A.

3604 S. Cooper Street, Suite 120

Arlington, TX 76015

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

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 _____