Medical Release Form

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____

City: _____ Zip Code: _____

Please choose release request:

____Full Record ____Immunization Record Only

INFORMATION REQUESTED FROM (CLINIC NAME)

Name: _____

Address: _____ City: _____ State: _____

Phone: (_____) _____ Fax: (_____) _____

SEND INFORMATION TO

Name: **Kidsville Pediatrics (McKinney)**

Address: 5881 Virginia Pkwy Suite 300, McKinney TX 75071

Phone: (469) 885-9400 FAX: (469) 886-1944 Email: mckinney@kidsvillepeds.net

I, _____(Name), hereby grant permission for you to release confidential health information about me, or my child, by releasing a copy of my medical record, or a summary of my protected health information, to **Kidsville Pediatrics**.

_____ _____
Printed Name Date

_____ _____
Signature Date