HEALING CARE
pediatrics

Request for Release of Health Records Form

Patient Name: _____ Date of Birth: _____

I as the parent or legal representative of the patient, request that the following protected health information (medical records) be released for treatment purposes.

PLEASE only send Vaccine Record and Problem List unless specified otherwise -
* DO NOT SEND FULL MEDICAL RECORDS *

Please initial on line below:

_____VACCINE RECORDS & PROBLEM LIST & LAB REPORTS

Release the medical record of the patient named above from the following medical provider:

Name of Physician or Medical Practice: _____

Address/City/State/Zip _____

Phone: _____ Fax: _____

Please send the records to: Healing Care Pediatrics / Dr. Khanum Saleha

Address: 12530 Lebanon Rd Ste 203 Frisco, TX 75035 Ph: (972) 200-7862 Fax: (972) 200-7949

I understand that federal laws and regulations do not require an authorization for release of protected health information for treatment purposes. This form is to provide a formalized written manner of communication for requesting protected health information from one healthcare provider to another. This health request will expire in 180 days unless otherwise revoked.

_____ _____ _____

[Name of the authorized representative to patient] *[Phone]* *[Relationship to patient]*

_____ _____

[Signature of authorized representative to patient] *[Date]*

I understand that the records released may include information related to Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome and/or treatment for or history of drug or alcohol abuse, mental, behavioral or psychiatric care. I understand this authorization is voluntary & I may refuse to sign it.