



Dr. Samuel Davis, MD

604 E. Bailey Boswell Rd
Suite 140
Saginaw, TX 76131
Office: (817) 484-6610
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MEDICAL RECORD RELEASE AUTHORIZATION

Parent or Guardian Name
Address
City/State/Zip
Phone#

I authorize the release of medical health information from the medical record of:

PATIENT NAME DATE OF BIRTH

Reason for request:

Request Records From:

- Office
Address
Phone/Fax #

To Be Sent To:

Child Plus Pediatrics
604 E. Bailey Boswell Rd., #140
Saginaw, TX 76131
Fax: 817-570-0181

AND/OR

Request Records From:

- Child Plus Pediatrics
604 E. Bailey Boswell Rd., #140
Saginaw, TX 76131

To Be Sent To:

Office
Address
Phone/Fax #

Please release the following:

- Immunization Record
Most Recent H & P
X-Rays/Radiology Reports
Other
Newborn Hospital Assessment Record
Therapy Reports
Laboratory Results

I understand that medical records may contain information relating to acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to insurance companies when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR-164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about this disclosure of my health information, I can contact Child Plus Pediatrics.

Signature of Parent or Legal Representative

Date

Relationship to Patient