

# Medical Records Release Form

By signing this form, I authorize you to release confidential health information about my child, by releasing a copy of my child's medical records, or a summary or narrative of the protected health information, to the person(s) or entity listed below.

**HIV/AIDS:** I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Child's name & Date of Birth** \_\_\_\_\_

**Limitations on the information you may release subject to this Release Form are as follows:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Release my child(s) protected health information to the following person(s)/entity:**

**Name:** Cedar Park Pediatrics (512) 335-9600 FAX (512) 335-9696

**Street:** 200 Buttercup Creek Blvd, Suite 100

**City:** Cedar Park **State:** TX **Zip:** 78613

**The reasons or purposes for this release of information are as follows:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Where do we request records from** \_\_\_\_\_

\_\_\_\_\_

**Patient signature (or parent, guardian or legal representative):**

\_\_\_\_\_

**Date:** \_\_\_\_\_

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.