# Medical Records Release Authorization

**I hereby request the medical records for**:

_____ _____

Patients Name Date of Birth

☐ I am transferring to Lone Star Pediatrics and wish that my records be released to the address/fax information below.

☐ I am transferring FROM Lone Star Pediatrics and wish that my records be released to the information I have provided.

☐ I am a current patient of Lone Star Pediatrics and need a portion of the medical record to be released to the following entity/person.

☐ I would like to request a paper copy of my medical records and understand that there will be a cost associated with copying my medical records.

To be released to:

Practice/Institution Name/Person:_____

Address:_____

Phone Number:_____

Fax Number:_____

**Portion of records requested (Please check which portion of the medical record to send)**:

☐ Immunizations

☐ Lab Results

☐ Radiology/ MRI/ X-Ray

☐ Progress Notes Dates of Service:_____ to _____.

☐ **All records (Please check this box if you wish to transfer entire medical record)**

Records to be released to:

Lone Star Pediatrics
12120 Ranch Road 620 North
Austin, Texas 78750
(512) 833-7334 - PHONE
(512) 833-7333 - FAX

_____ _____

Parent/Guardian Name Relation to Patient

_____ _____

Parent/Guardian Signature Date