CRAIG RANCH
PEDIATRICS

Medical Records Release Form

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

Patient Name _____

D.O.B. _____

Name of entity/ person from whom records are requested:

_____

_____

_____

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

Craig Ranch Pediatrics
6850 TPC Drive, Suite 100,
McKinney, TX 75070
Ph: 214-383-4400
Fax: 214-383-4403

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

_____

_____

_____

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.