FRISCO PEDIATRICS, P.A.
Kathleen D. Stokes, M.D.
Late Sheldhauer, M.D.
6930 Parkwood Boulevard Frisco, Texas 75034
Telephone: 972-335-4444 Fax: 972-335-0880

Authorization For Release of Medical Records

Patient Name:_____

Address:_____

Date of Birth:_____Phone Number:_____

I hereby authorize_____

(phone number) _____ (fax number) _____

to release the following medical information to:

Frisco Pediatrics, P.A.

6930 Parkwood Boulevard

Frisco, Texas 75034

Please release:

☐ Complete Records

☐ Other:_____

Please exclude the following specified information:_____

_____

This authorization covers care provided from_____to_____.

Purpose of disclosure: ☐ Medical Care ☐ Employer ☐ Insurance

☐ Attorney ☐ Other:_____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. This authorization is valid for 120 days from the date of signature.

Signed:_____Date:_____

Patient, Parent or Legal Guardian

_____

Relationship to Patient