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Medical Records Release Request Form

I hereby authorize _____ to release any confidential health information. By signing this form, I consent to the release of medical records, or a summary or narrative of my protected health information.

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 Date of Birth: _____	Child's Name: _____ Last First Middle
Child's Social Security #: _____	Address _____ City State Zip
Type of information needed and purpose for the release: _____ _____ / _____	

All information released by the sending physician shall be held as confidential by the receiving physician / organization.

Release information to: _____
Address: _____
Phone #: _____ / Fax#: _____
Records released to: <input type="checkbox"/> Patient <input type="checkbox"/> Ins. Co. <input type="checkbox"/> Physician <input type="checkbox"/> Other

I hereby release said Physician or staff from all legal responsibilities or liability that may arise from the act I have authorized.

Print Name of Parent and / or Guardian

Date Signed

Relationship to patient

Signature of Parent and / or Guardian

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.