Acorn Pediatrics of San Antonio
15303 Huebner Road #9
San Antonio, TX 78248
(210) 697-2400
Fax (210) 697-2401

MEDICAL RECORDS RELEASE FORM

I hereby authorize release of a copy, summary, or narrative of my medical records or otherwise confidential information as indicated below from _____ to Acorn Pediatrics.

_____ Complete Records

_____ Immunization Record Only

_____ Record of Care for the Date _____ to _____

_____ Record Concerning the Following Condition _____

Name of Physician: _____

Phone Number: _____

Fax: _____

HIV/AIDS: I consent to the release of positive or negative results for AIDS/HIV infection along with the rest of my records.

Initial _____ Date _____

Patient(s) Name: Date of Birth

_____

_____

_____

Please release records to Acorn Pediatrics of San Antonio at the address above. I understand that you will provide copies of records within 15 days from receipt of request and the patient may be charged a fee for furnishing this information according to the ruling set forth by the Texas State Board of Medical Examiners. Records may be transmitted electronically. I hereby represent that I am authorized to request records for the patient above.

Patient (Parent/Guardian if a minor) Signature: _____ Date: _____

Parent Name: _____