19333 Hwy 59 North, Suite 145
Humble, TX 77338
Phone (281) 540-5437 - Fax (281) 540-2630

REQUEST FOR MEDICAL RECORDS

Please mail or fax to address or number above

Fecha de Hoy: _____

Nombre de Paciente: _____ D.O.B: _____

Domicilio: _____
(Nombre de calle, Appt., Cuidad, Estado, Codigo Postal)

Numbero de casa #: _____ Celular #: _____

Yo, _____ hereby request to obtain/release medical information from/to:

*** POR FAVOR DE LLENAR POR COMPLETA LA INFORMACION **NO LO DEJE SIN COMPLETAR****

* {
*_____
Nombre de Clinica o Doctor
*_____
Domicilio
*_____
Cuidad, Estado y Codigo postal
*(_____)_____
Numero de Oficina #
*(_____)_____
Numero de Fax #

OFFICE USE ONLY
Med Rec. Req by: _____
Date Req: ____/____/_____

Rec Received on: ____/____/_____
Received by: _____

Expiration Date: ___/____/_____

Please include the following records: (Check all that apply)

- All Medical Records
- Labs
- H & P Progress Notes
- Immunizations

Please include medical records pertaining to (initial requested area):

- Emotional Mental Health/Psychiatric Condition
- HIV/AIDS/STD's
- Drug/alcohol/Substance Abuse

Reason for Transfer:

- Moving to a new area
- Moving to a closer clinic
- Patient has outgrown pediatric age
- Transferring care to a new pediatrician due to:
  - Medical care of child(ren)
  - Wait time in office
  - Difficulty scheduling appointments
  - Interaction with office staff
  - Other: _____

* _____ _____/_____/_____
Parent/Guardian Signature Date

19333 Hwy 59 North, Suite 145
Humble, TX 77338
Phone (281) 540-KIDS - Fax (281) 540-2630

REQUEST FOR MEDICAL RECORDS

Please mail or fax to address or number above

Date: _____

Patient Name: _____ D.O.B: _____

Childs Address _____
(Street and apt#, City, State, Zip)

Primary Tel. Number _____Alternative Tel. Number_____

I, _____ hereby request to obtain/release medical information from/to:

PARENTS/GUARDIAN PLEASE FILL OUT BELOW INFORMATION **DO NOT LEAVE IT BLANK*

*_____
Name of Clinic/Doctor
*_____
Address
*_____
City, State, Zip Code
*(_____)_____
Office Phone #
*(_____)_____
Office Fax #

OFFICE USE ONLY
Med Rec. Req by: _____
Date Req: ____/____/_____

Rec Received on: ____/____/_____
Received by: _____

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  - Other: _____

_____ _____
Parent/Guardian Signature Date