Ancor Pediatrics, PA

AUTHORIZATION FOR RELEASE OF RECORDS

Date: _____

PATIENT INFORMATION

Patient Name: _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (Zip)

Phone: ( ) _____ DOB: _____ SSN: _____

RELEASE INFORMATION

I hereby authorize: Ancor Pediatrics
703 E. Marshall Ave., Suite 3007
Longview, Texas 75601
Phone: 903-236-8600 Fax: 903-236-8605

To release my medical records information to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

REQUEST INFORMATION

Records Requested: ☐ Entire Record ☐ Lab ☐ X-Ray ☐ Progress Notes
☐ Hospital Records ☐ Other: _____

Special Information: ☐ Substance Abuse ☐ Psychiatric/Mental Health Information ☐ HIV Information

Reason for Request: ☐ Transfer of Care ☐ Consultation
☐ Other: _____

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THIS CONSENT AUTOMATICALLY EXPIRES THIRTY (30) DAYS FROM THE DATE OF MY SIGNATURE OR AS OTHERWISE SPECIFIED BY DATE, EVENT OR CONDITION AS FOLLOWS:

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Relationship to Patient Witness