Medical Record Release

To whom it may concern:
I hereby authorize the release of my child(ren)'s medical records, or copies of such, and request that they be transferred from your office to **Continuum Internal Medicine & Pediatrics**, as soon as possible.

From:

Office Name _____

Address _____

City _____ State_____ ZIP_____

Phone _____ Fax _____

To: Kathryn K. Mandal, MD, FAAP
Krystyna Wesp, DO
Elizabeth A. Becker, MD
Continuum Internal Medicine and Pediatrics
9509 N. Beach St, Suite 102
Fort Worth, TX 76244
ph. 817.617.8600
fax 1.877.906.1852

Check the records to be disclosed:

☐ Immunizations ☐ Growth Charts ☐ Other: _____

Below are my child(ren)'s names and date(s) of birth:

Name_____ Date of Birth____/_____/_____

Name_____ Date of Birth____/_____/_____

Name_____ Date of Birth____/_____/_____

Name_____ Date of Birth____/_____/_____

I understand that these records may contain details regarding psychiatric illness, drug or alcohol treatment, HIV/AIDS testing and status, sexually transmitted disease diagnosis and other sensitive medical information of either my children, myself, or my child's other parent.

Parent's name_____ Relationship to patient_____

Parent's Signature_____ Date_____

Contact phone number _____