Parsi Pediatrics
9819 Huebner Rd, Bldg 2
San Antonio, TX 78240

Main Office:
Phone: 210 – 561 – 1551
Fax: 210 – 561 – 0552

MEDICAL RECORDS RELEASE FORM

This authorizes you to provide a copy, summary, or narrative of my medical records (as indicated by checkmarks below) or otherwise release confidential information.

_____ Complete Records

_____ Newborn complete records

_____ Immunization Record Only

_____ Records of care from the follow date:_____TO_____

_____ Records concerning the following conditions:_____

Patient Name:_____ Date of Birth_____

Mothers Name:_____ Date of Birth_____

HIV/AIDS: I consent to the release of any positive or negative test results for **AIDS** or **HIV** infection, antibodies to **AIDS** of infections with any other causative agent of AIDS with the rest of my medical records.

Initial:_____ **Date:**_____

Release to the following physician or person(s)

Name: Parsi Pediatrics **Office Number**: (210) 561-1551 **Fax Number**: (210) 561-0552
Address: 9819 Huebner Rd, Bldg 2 **City**: San Antonio **State**: Texas
Zip code: 78240

Request from:

Physician / Hospital Name: _____ **Office Number:** _____

Address: _____ **Fax Number:** _____

City: _____ **State:** _____ **Zip code:** _____

IF MORE THAN 20 PAGES, PLEASE MAIL

I understand that you will provide copies of medical information within 15 days from receipt of request.

Patient (parent, if minor) signature:_____ Date: _____

Office use only: Faxed or Mailed Date: _____ Initial: _____ DATE RECEIVED: _____