PSOP KIDS
PEDIATRIC SPECIALISTS OF PLANO

Pediatric Specialists of Plano
3405 Midway Road, Suite 650
Plano, Texas 75093
Ph 972.473.7777 Fax 972.473.7780
www.psopkids.com

Patient Name: _____ D.O.B: _____

Patient Name: _____ D.O.B: _____

Patient Name: _____ D.O.B: _____

Dear Dr/Facility: _____

Address: _____

Phone: _____ Fax: _____

Please release the following information:

Immunizations _____ Growth Chart _____ Problem List _____ Labs _____

Other _____ Records of care concerning: _____

By signing this form, I authorize you to release confidential health information about me or my child, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed above. HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.

This letter authorizes you to release the above information to the following person(s) for the continuation of the patients care:

Pediatric Specialists of Plano
3405 Midway Road, Suite 650
Plano, Texas 75093
**If less than 70 pages please fax to:**
972.473.7780

I understand that you will provide this information within 30 business days from receipt of this request.

Parent Signature: _____ Date: _____