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 **Dr. Kathryn Mandal**, at **Continuum Internal Medicine and Pediatrics**, as soon as possible.

From:

Office Name _____

Address _____

City _____ State_____ ZIP_____

Phone _____ Fax _____

To: Kathryn K. Mandal, MD, FAAP
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:

☐**Complete records**	☐**Immunizations**	☐Growth Charts
☐Lab results	☐Consultations	☐Radiology Reports
☐Operative reports	☐Summary of visits	

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 _____