Kangos Pediatrics

12411 Hymeadow Drive, Suite 3F, Austin, TX 78750 Phone: (512) 250-1997 Fax: (512) 250-1529

MEDICAL RECORDS RELEASE

A $25.00 fee will be assessed for request of release of Medical Records from Kangos Pediatrics to Parent/Guardian.
Payment, where applicable, is required prior to executing this records request.
Transfer of records directly to another provider, for continuity of care, is done as a courtesy at no charge.

Patient Name: _____ DOB: _____

I, hereby request and authorize the Physicians and Staff of Kangos Pediatrics to use or disclose my protected health information (PHI) subject to the following authorization:

Please select and complete the appropriate option:

_____RELEASE RECORDS TO:

NAME:_____
PHONE NUMBER:_____
ADDRESS:_____
_____
FAX NUMBER:_____

_____RELEASE RECORDS FROM:

NAME:_____
PHONE NUMBER:_____
ADDRESS:_____
_____
FAX NUMBER:_____

The information to be used or disclosed:
_____ Complete record
_____ Records of care from _____ to _____ only
_____ Immunization Record: _____

The reason or purpose for this release of information: _____

This authorization shall remain in force and effect until it expires on this specified date:_____.
If I fail to specify a date, specific event or condition, then this authorization will expire in one year.
I understand I have a right to revoke this authorization in writing, except to the extent that action has already been taken in reliance on this authorization. For the revocation of this authorization to be effective, we must receive a notice in writing.

I understand that this information will be provided within 15 business days from receipt of request.

Signature of Parent or Guardian:_____ Date: _____