Hilltop Pediatrics
300 Highland Ave.Ste.542 | Sherman, TX 75092
Phone: 903.957.0050 | Fax: 903.957.0057

Medical Records Release Form

PATIENT NAME: _____ DATE OF BIRTH: _____/_____/_____

By signing this form, I authorize you to release confidential health information about (me)(my child), by releasing a copy of (my)(my child's) medical records, or a summary or narrative of (my)(my child's) protected health information, to the person(s) or entity listed below.

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

Limitations on the information you may release subject to this Release Form are as follows:

_____

_____

_____

Release my protected health information to the following person(s)/entity:

Name: _____

Street: _____

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

The reasons or purposes for this release of information are as follows:

_____

_____

_____

Patient signature (or parent, guardian or legal representative):

_____

Date: _____

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.