INBOUND MEDICAL RECORD RELEASE

I, _____ (name), _____ (relationship) of,

_____ (patient's name), DOB: _____

Home Address:

_____

_____

Cell phone #: _____

Hereby authorize the release of his/her medical records from:

Name of Provider/Institution:

_____

Address:

_____

_____

Phone #: _____ Fax #: _____

To be forwarded directly to: Stonebriar Pediatrics, P.A.

Stonebriar Pediatrics, P.A.
2840 Legacy Dr. Suite 210
Frisco, TX 75034
Phone: (972) 668-7110
Fax: (972) 668-7135

I recognize that I may revoke this consent at any time, except to the extent that the information has already been released in reliance to this form. If not revoked, this consent will expire one year from the date signed.

_____ _____

Signature of patient or legal representative Date