



**Authorization for Release of Medical Information**

**Please Request Medical Information FROM:**

\_\_\_\_\_  
Name of Person/Facility

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State and Zip Code

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

**I hereby authorize the above stated person/facility to release the complete medical record, unless specified below, to Pediatric Associates of Wylie, P.A.**

**Release records regarding:**

\_\_\_\_\_  
Patient Name                      Patient DOB                      Patient Telephone Number

\_\_\_\_\_  
Patient Address                      Patient City, State                      Patient Zip Code

\_\_\_\_\_  
Signature of parent / legal guardian                      Date: \_\_\_\_\_