Shine
Pediatrics and Wellness Center, PA
(Office) 469-333-1543 (Fax) 1-877-878-9118
Email: shine@shinepediatrics.com
www.shinepediatrics.com

Authorization for Release of Medical Records

Patient Information	**Name:**_____ **DOB:**_____ **Address:**_____ **City/State/Zip:**_____ **Phone:**_____ **Email:**_____
Requested By	**Name:**_____**Phone:**_____ **Relationship/Capacity to Patient:**_____
Send to	**Name:**_____ **Attention to:**_____ **Address:**_____ **City/State/Zip:**_____ **Phone:**_____ **Fax:**_____ **Email:**_____
Information to be Released	**Please check ALL that apply:** ☐ **X-rays/Labs** ☐ **Vaccines** ☐ **Growth Charts** ☐ **All Medical Records (including previously listed)** ☐ **Other (please specify):**_____ ***Please Note: there will be a $25 fee assessed when requesting a HARD COPY of medical records.**

_____
Printed Name of Guardian/Authorized Representative

_____ _____
Signature of Guardian/Authorized Representative Date

PRINT, SIGN AND E-MAIL THIS FORM TO shine@shinepediatrics.com OR FAX TO 1-877-878-9118. INCLUDE THE WORD 'RECORDS' IN THE SUBJECT LINE.