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:**_____
Please Send Records to:	**Please check one:** ☐ **Name/Physician:**_____ **Address:**_____ **City/State/Zip:**_____ **Phone:**_____ **Fax:**_____ **Email:**_____ **Or** ☐ **Shine Pediatrics and Wellness Center** **3535 Victory Group Way, Suite 305, Frisco, TX 75034** **Phone: (469) 333-1543 Fax: (877) 878-9118** **Email: shine@shinepediatrics.com**
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.**

I request the checked records be released and sent to the above checked recipient.

_____ _____
Printed Name of Guardian/Authorized Representative | Relationship to Patient/Phone #

_____ _____
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.