




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: _____
Request Records From:	Name/Physician: _____ Address: _____ City/State/Zip: _____ Phone: _____ Fax: _____
Please Send Records to:	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: <input type="checkbox"/> X-rays/Labs <input type="checkbox"/> Vaccines <input type="checkbox"/> Growth Charts <input type="checkbox"/> All Medical Records (including previously listed) <input type="checkbox"/> Other (please specify): _____ <p style="text-align: center;">*Please Note: there will be a \$25 fee assessed when requesting a HARD COPY of medical records.</p>

 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.