HAPPY DAYS PEDIATRICS

8700 Crownhill Blvd, Suite 210 San Antonio, TX 78209
Phone: 210-816-1330

REQUEST FOR RELEASE OF MEDICAL RECORDS

To: _____ Ph: _____

Physician's name: _____ Fax: _____

Address: _____

City _____ State _____ Zip _____

I hereby request that my child's (children's) complete medical records (to include, but not limited to, vaccine records, growth charts, clinic notes, all correspondence) be released to the office below for continuity of medical care:

Happy Days Pediatrics
8700 Crownhill Blvd, Suite 210
San Antonio, Texas 78209
Ph: 210-816-1330 Fax: 210-855-9169

I understand that this authorization is valid for 365 days after the date of my signature below, that I may revoke my authorization in writing at any time, and that the disclosed information may be subject to redisclosure by Happy Days Pediatrics to other health institutions upon request.

Parent's name: _____ Date: _____

Parent's signature: _____

Child's name: _____ DOB(s) _____

Child's name: _____ DOB(s) _____

Child's name: _____ DOB(s) _____

Child's name: _____ DOB(s) _____

Child's name: _____ DOB(s) _____

Child's name: _____ DOB(s) _____

Child's name: _____ DOB(s) _____

Child's name: _____ DOB(s) _____

PLEASE SEND VACCINE RECORDS ASAP