Medical Records Release to Barton Creek Pediatrics

I hereby authorize

Physician/Practice: ______________________________

Street ______________________________

City,State ______________________________

phone ______________________________

to release the medical record(s) of my child/children:

Patient Name(s)

______________________________ D.O.B. ____________

______________________________ D.O.B. ____________

______________________________ D.O.B. ____________

______________________________ D.O.B. ____________

to:

Valerie Wheelock, M.D.

Barton Creek Pediatrics

7004 Bee Caves Road

Building 1, Suite 210

Austin, Texas 78746

phone: 512-327-0562 fax: 512-327-8219

Information to include:

________ Medical Summary	________ Growth Charts	________ Progress Notes
________ Operative Reports	________ Physical	________ EKG Report
________ Lab Reports & Xrays	________ Care Plan	________ Therapy Notes
________ Psychological Rpts	________ Immunizations	________ Office Notes

Reason for disclosure request:

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I understand that I may revoke this consent at any time except to the extent that action has already been taken, this authorization expires automatically ninety (90) days from the date of signature, and that photocopy of the authorization may be considered valid.

______________________________ ____________

Signature of parent/guardian Date