Authorization for Release of Medical Records

Patient Name(s) :_____

D.O.B.:_____Phone Number:_____

Address:_____

I hereby authorize:_____

Office Phone:_____Office Fax:_____

Office Address:_____

To release copies of any medical records* concerning any illness, treatment, or recommendation while a patient of the above listed medical facility, or physician(s).

***I UNDERSTAND THAT MY MEDICAL RECORD MAY CONTAIN COPIES OF INFORMATION RECEIVED FROM ANOTHER HEALTH CARE FACILITY OR PHYSICIAN(S), THESE CANNOT BE RELEASED WITHOUT AUTHORIZATION FROM THE FACILITY OR PHYSICIAN(S).**

I also understand that the above information may contain reference to or results of HIV (AIDS) antibody testing, testing or treatment of communicable diseases, treatment for mental health problems, alcohol history, or substance abuse, and I authorize the release of such confidential information to the indicated party.

Information to be released:_____ Entire Medical Records

_____Other (Specify) _____

These records should be released to:

Compass Pediatrics, PLLC

Tamara Bavousett DNP, RN, C-PNP

5113 Wayland Drive

Odessa, TX 79762

432-332-2080

Fax- 866-298-7237

Signature of Parent/Patient:_____Date:_____

Relationship to patient:_____

Witness:_____Date:_____