Texoma Pediatrics

Records Release Form

I, _____ (Name), _____ (Relationship), of:

Patient's Name: _____

Date of Birth: _____

Home Address: _____

_____

Home Phone #: _____

Hereby authorize the release if his/her medical records from:

Name of Provider/Institution: _____

Address: _____

_____

Phone #: _____

Fax #: _____

To be forwarded directly to:

Texoma Pediatrics, PLLC
1415 W. Main St., Suite 300
Durant, OK 74701
Phone: (580) 920-1980
Fax: (580) 920-9937

I recognize that I may revoke this consent at any time except to the extent that the information has already been released in reliance of this form. If not revoked, this consent will expire one year from the date signed.

_____ _____

Parent/Guardian Signature Date