Bright Futures Pediatrics

6850 N. Durango Drive Ste 120
Las Vegas, NV 89149
Fax (702) 826-4244
Phone (702) 944-4028

8352 W. Warm Springs Rd. Ste 210
Las Vegas, NV 89113
Fax (702) 944-4019
Phone (702) 944-4028

MEDICAL RECORDS RELEASE FORM

This form authorizes the recipient to provide a copy, summary, or narrative of my child's medical records or otherwise release confidential information.

- o Complete record
- o Records of care for the following dates _____to _____
- o Records concerning the following conditions :_____
- o Other, please specify: _____

Patient's Name: _____ Date of Birth: _____/_____/_____

Patient Address: _____

Please send my records to / from (circle one):

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Records to be released to / from (circle one):

Physician's Name: _____ Phone # (_____) _____ Fax# (_____) _____

Complete Address: _____

_____

I understand the following:
a. I have the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
Any facsimile, copy, or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be enforced and in effect indefinitely.

Print Name of Parent or Guardian: _____

Parent or Guardian Signature: _____ Date:_____