WONDERKIDS PEDIATRICS

Medical Records Release Form

Patient name: ________________________________ DOB__________________

Patient name: _________________________________DOB__________________

Patient name _________________________________ DOB __________________

Patient name: _________________________________DOB__________________

Patient name: _________________________________DOB__________________

Patient Address: ____

Phone number: ____

Secondary Phone number ____

I authorize the following person/organization to disclose my child's protected health records to Wonderkids Pediatrics.

Previous Pediatrician/Office Contact Information:

Office/ Hospital Name: ____

Pediatrician Name: ____

Phone: ____________________________Fax___________________________________

Address: ____

Please release medical records to:

Wonderkids Pediatrics Dr. Demetrios Leiloglou

20818 Gathering Oak, Suite 109, San Antonio, Tx 78260

Phone: 210-762-6464 ~ Fax: 210-762-6465 ~ wonderkidspediatrics@mdofficemail.com

Reason for disclosure (check one):

___ Treatment

___ Continuing Medical Care

Information to be Disclosed (check one)

___ All Health (full records)

___ Other: Immunizations

Name of Parent/Guardian Printed: ____

Signature: ____ Date: ________________