10755 Kenworthy Street, El Paso, Texas ***Office:*** 915-821-5900 ***Fax:*** 915-821-5902

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient Information (Pease Print):

Name: _____

Date of Birth: _____

Social Security Number: _____

Address: _____

_____

Please release my medical records from:

Name of Office or Doctor: _____

Tel: _____ Fax: _____

TO

Northeast Cornerstone Pediatrics, PA
10755 Kenworthy Street
El Paso, Texas 79924

Please send medical records no later than: _____

Release a copy of ALL my medical records, including but not limited to, progress notes, operative notes, laboratory results and diagnostic tests.

By my signature I authorize the Release of All Medical Records

Authorized Signature for child: _____ Date: _____