

**HEBRON PEDIATRICS**  
Patient Registration Form

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone: \_\_\_\_\_

I hereby authorize the release of the following records from:

**Facility Name: Hebron Pediatrics Facility Phone: 972-695-9630 Fax: 972-694-0000**

Facility Address: 3020 E Hebron Pkwy, Ste 300, Carrollton, TX 75010

To

Doctor/Facility Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

The information requested is as follows:

- Immunization Records
- Other: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Date: \_\_\_\_\_