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: 2008 E Hebron Pkwy, Ste 120, Carrollton, TX 75007

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: _____