CHILDREN'S HEALTH
Dallas-1935 Medical District Drive
Dallas, Texas 75235
Fax: (214)456-6170
Plano - 7601 Preston Road
Plano, Texas 75024
Fax: (469) 303-4084

First Name: _____ Middle Initial: _____

Last Name: _____

Date of birth: _____

ROIF
CMC79772-001NS Rev. 10/2017

Patient Access Request for Health Information

I am the patient or legally authorized representative (e.g., parent, legal guardian) of the patient and I request and authorize Children's Health to release the health information of the above named patient as follows:

Date(s) of Service: _____ /_____ /_____ through_____ /_____ /_____

What records do you want? (Check appropriate boxes below):

- ☐ Discharge summary
- ☐ Emergency room notes
- ☐ Operative / Procedure notes
- ☐ Test reports: Labs, X-rays, pathology, EKG, EEG, CT scan
- ☐ Clinic / Physician Note _____
- ☐ Immunization / Shot records
- ☐ Radiology images on CD
- ☐ Billing Record
- ☐ Photographs
- ☐ Other (specify): _____

STAT ☐ I have appointment scheduled for date: _____
* These records will be provided in time for the visit.

How would you like the information delivered?

☐ Electronic (Email, CD, USB, Portal, Other) Please specify: _____

We will send email communications encrypted, as email is not a secure form of communication. If you prefer we do not encrypt the email containing medical record information, please initial here: _____

☐ Paper

- ☐ In-Person pickup / call back number: _____
- ☐ Mailed

Where do you want the information mailed or faxed to?

Name: _____

Mailing Address: _____

City / State / Zip: _____

Phone number: _____

Fax number: _____

_____ _____ _____
Signature of Patient or Legally Authorized Representative | Date | Time

_____ _____
Printed Name of Patient or Legally Authorized Representative | Relationship to Patient