PLAYWORKS
THERAPY GROUP
OF TEXOMA

Playworks Therapy Group
Medical Records Release Form

Patient Name	*DOB*

Sending from

I hereby authorize the following health care professional, medical facility, medical records service, school or family member to release health information

Name of sending organization: _____

Address: _____

Phone #: _____ Fax #: _____

Release to

Name of organization: _____

Attention: _____

Address: _____

Phone #: _____ Fax #: _____

Records sending or requesting: _____

- I understand that I am entitled to receive a copy of this authorization
- I understand that this authorization will not expire, and I may submit in writing to withdraw this authorization
- I understand that there is a $25.00 medical record fee due at time of request

Please select one:

____1. Request records to be printed and given directly to parent/legal guardian

____2. Request records to be sent electronically to provider *(this option will avoid the $25.00 record fee)*

Parent/Legal Guardian printed name: _____

Parent/Legal Guardian signature: _____

Date: _____

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