Kid Approved Pediatrics, PLLC
11875 Coit Rd, Ste 100
Frisco, TX 75035

Authorization to Release Confidential Medical Information

I hereby request that my medical records be released to:

Facility: Kid Approved Pediatrics, PLLC

Address: 11875 Coit Rd. Suite 100
Frisco, TX 75035

Phone: 972-787-0044 Fax: 214-382-0065

My records are being transferred from:

Facility:_____
Address:_____
City:_____ State: _____
Phone:_____ Fax:_____

Reason for request of records: _____

___Entire Health History __Test Results ___Growth Chart & Immunization Records

___Other:_____

As the guardian of the patient named below, I give permission to release all medical, mental, and social information to the facility listed. I understand that this information is confidential and will only be used for the benefit of the patient. I further understand that this release is valid for one year or until I revoke the authorization in writing.

Patient Name: _____ Patient DOB: _____

Patient Name: _____ Patient DOB: _____

Patient Name: _____ Patient DOB: _____

Parent Signature:_____ Date:_____

Parent Printed Name:_____

PLEASE RETURN FORM TO KAP BY EMAIL: staff@kidapprovedpediatrics.net