The CDG Family Network

Authorization for Disclosure of Health Information
Consent for Release of Information

Patient Name:________________ Date of Birth:______________

Address:____
Street City State Zip

I,________________________________, parent/guardian of the above mentioned patient, hereby request and authorize:

Name of Facility/Person:____

Address:____

To release information from my child's health record to:

The CDG Family Network

Please release the requested information from the above mentioned patient's medical record to:

The CDG Family Network
P.O. Box 860847
PLANO, TX 75074-0847

Thank you for your time.

___History and Physical
___Discharge Summary
___Entire Record
___Therapy/ies Reports
___Emergency Summary
___Nurse Specialist Summary
___Operative reports
___Consultation Reports
___X-Rat Report
___EKG Report
___Pathology Report
___Brief Summary of Last visit
___ Other (specify)____

______________________________ ______________________________
Signature of Parent/Guardian Date Witnesss Date