

West Texas Pediatrics, L.L.P.

**5215 – 96th Street
806-780-6868**

**Lubbock, TX 79424
Fax 806-780-2065**

Dear Dr. _____

This letter will authorize you to provide a copy, summary, or narrative of my children's medical records (as indicated by the checkmark below)

Complete record _____
Records of care only from _____ to _____
Records of care concerning the following condition(s) _____
Shot Record Only _____

to the following:

**West Texas Pediatrics, L.L.P.
5215 – 96th Street
Lubbock, TX 79424**

The reasons or purposes of this release of information are as follows:

I understand that you will provide this information within thirty (30) days, and that a reasonable fee for furnishing this information may be charged.

Patient Name: _____ Date of Birth _____
Patient Name: _____ Date of Birth _____
Patient Name: _____ Date of Birth _____

Signed: _____ Date: _____
Patient (or person legally authorized to consent on patient's behalf)