



Dr. K's Kids Pediatrics  
1670 Keller Parkway, Suite 170  
Keller, TX 76248  
Phone: (817)741-4144  
Fax: (817)741-4154

Date of Request: \_\_\_\_\_

Name of Doctor or Clinic to Release Records:  
\_\_\_\_\_  
\_\_\_\_\_

Name of Parent / Legal Guardian: \_\_\_\_\_

Patient's Name and Date of Birth: \_\_\_\_\_  
\_\_\_\_\_

Request Records to be Forwarded to:  
Shari Kushwaha, M.D.  
1670 Keller Parkway, Suite 170  
Keller, TX 76248  
FAX: (817)741-4154

Mail \_\_\_\_\_ Fax \_\_\_\_\_ Verbally \_\_\_\_\_

**Records to Transfer:**

\_\_\_\_\_ All Records: including immunization records, growth charts and labs

\_\_\_\_\_ Shot Records & Growth Charts

\_\_\_\_\_ Consultation Notes

\_\_\_\_\_ Hospital Records: \_\_\_\_\_  
Include Labs & X-ray results Date

\_\_\_\_\_ Discharge Records: \_\_\_\_\_  
Date

\_\_\_\_\_ Urgent Care Records: \_\_\_\_\_  
Include Labs & X-ray results Date

- I understand that I may revoke this authorization at any time by notifying the office in writing. I understand this authorization expires 180 days from the date signed.
- I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws/regulations.
- I understand that photocopy or facsimile of this authorization is as valid as the original.

\_\_\_\_\_  
**Signature of Parent/Legal Guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness/Office Staff**

\_\_\_\_\_  
**Date**

Office Use: Date Sent: \_\_\_\_\_

Date Received: \_\_\_\_\_ Date Received: \_\_\_\_\_