

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name _____ Medical Record # _____

Date of Birth _____ Social Security # _____ (optional)

I authorize the following individual or organization to disclose the above named individual's health information:

_____ Address: _____

This information may be disclosed TO and used by the following individual or organization:

Pediatric Place, 3801 W. 15th Street, Bldg D suite 120, Plano, TX 75075

Fax: 972-964-0563 Phone: 972-519-0545

For the purpose of: _____

Please release the following:

- Entire Record
or: Problem List X-Ray/Imaging Reports-from (date) _____ to (date) _____
 Progress Notes X-Ray Films
 History/Physical Exam Laboratory Results-from (date) _____ to (date) _____
 Medication List EKG Reports
 Immunization Record Genetic Testing Information
 List of Allergies Other Diagnostic Reports (Specify) _____
 Other (Specify) _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Yes, I consent to the release of this information. No, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date: _____.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Kelle Maynard at 972-519-0545.

Signature of Patient or Legal Representative _____

Date _____

Relationship to Patient (If Legal Representative) _____

Witness _____

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold _____ liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Signature of Patient or Legal Representative _____

Date _____

Date request completed _____ # pages copied _____ Reviewed only _____

Charges \$ _____ Cash _____ Check # _____ Initials _____

[All articles and any forms, checklists, guidelines and materials are for generalized information only, and should not be used or referred to as primary legal sources, nor construed as establishing medical standards of care. They are intended as resources to be selectively used and always adapted- with the advice of the organization's attorney- to meet state, local, individual organizations and department needs or requirements. It is distributed with the understanding that neither Texas Medical Liability Trust's Risk Management Department nor Texas Medical Liability Trust is engaged in rendering legal services.]