mdpediatric ASSOCIATES

Authorization for Release of Medical Information

Patient Name_____ Date of Birth_____

Home Phone_____ Cell/Work_____

Address_____ City/State/Zip_____

Email Address: _____

A) I hereby authorize records FROM:

Name_____

Address_____

City/State/Zip_____

Phone#_____ Fax#_____

B) To be released TO:

Name_____

Address_____

City/State/Zip_____

Phone#_____ FAX#_____

C) For the purpose of:

- ☐ Litigation
- ☐ Insurance
- ☐ Self/Personal Copy
- ☐ Continuity of Care
- ☐ Disability/SSI
- ☐ Work Comp
- ☐ Other
- ☐ Transfer of Care (Permanently Leaving)

Date Range_____ to_____

- ☐ Physician Office Notes
- ☐ Immunizations
- ☐ Operative/Procedure Reports
- ☐ Other _____
- ☐ Cardiology/EKG Reports
- ☐ Lab/Path Reports
- ☐ Radiology/XRay/MRI Reports
- ☐ Minimum Necessary

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 assure treatment. 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 the authorized individual or organization making disclosure.

I understand that the information in my medical 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.

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 Medical Records Department. I understand that the revocation will not apply to information that has already been 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.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____ ****Subject to Fees**

(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

This authorization will expire after release unless I specify an expiration date:_____ (Expiration date of authorization)

***PLEASE READ** Fee Information: **MD Pediatric Associates** contracts with an outside organization to copy and provide most medical records requested from our office. The company reserves the right to charge the medical record state fee structure as set forth in the state statute. Copy charges plus postage will be invoiced to you with all of the necessary directions to receive your records. By signing this authorization, you are agreeing to pay for your records if a charge is incurred. In the case of continuity of care or personal copy to patient, we may transfer a summary of your records as a courtesy rather than the complete and total record.

P.O. BOX 2429, COPPELL, TX 75019 P: 972.420.1475 F: 469.671.5437 WWW.MDPEDI.COM