Pediatric Physicians, P.A.
3101 Churchill Drive, Suite # 200
Flower Mound, TX 75022
972-691-2100 972-691-2150fax

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I understand that my/my child's medical records are confidential and cannot be disclosed without my written authorization, except otherwise provided for by law. I hereby voluntarily authorize,

____
(To release the following information from) (Phone or Fax#)

____ _________________________
(Patient Name) (Birth Date)

The information specified below May be released to:

Pediatric Physicians, P.A.
3101 Churchill Drive Suite 200
Flower Mound, Tx 75022

The specific purpose(s) for this disclosure is/are:
[] My personal use
[] Sharing with other healthcare providers
[] Other (please describe) ____

SPECIFIC INFROMATION TO BE RELEASED: (Please check all that you are requesting be released)

____ Complete Medical Records for this Office
____ History & Physical
____ Other (Please List)____

- I understand that I May revoke this authorization at any time by notifying the office in writing at ATTN:
- Practice Manager, Medical Records Request of my intent to revoke this authorization, and that such revocation
- Will not have any effect on any actions taken by the office before revocation.
- I understand this authorization expires 180 days from the date signed, unless otherwise revoked.
- 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 or regulations.
- I understand that I May be asked to show proof that I have the authority to sign an authorization to review and/or receive copies
- of the above named patients medical record which I am requesting.
- I understand that I May be charged for copies of my/my child's medical record, which I request for myself for use by others.
- I also understand fees for copies are due and payable before copies are released.
- I understand that a photocopy or facsimile of this authorization is as valid as the original.

__________________ ____
Date Signature of Patient, Parent of Legally Authorized Representative

____________________________ ____________________________
Printed Name Relationship to Patient