



# Pediatric Associates

OF DALLAS

7859 Walnut Hill Lane, Suite 200, Dallas, Texas 75230  
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(214) 369-7661

## AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

The fee for providing a copy of your medical record release is \$25 for the 1st 20 pages and .50¢ each page thereafter.  
(Revised 7/16/2013)

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Contact Numbers ( ) \_\_\_\_\_ ( ) \_\_\_\_\_

I authorize the following organization to release information as stated below from the patient health information record:

INFORMATION TO BE RELEASED FROM:		INFORMATION TO BE RELEASED TO:	
<input type="checkbox"/> Pediatric Associates or <input type="checkbox"/> _____ Organization / Person	_____	<input type="checkbox"/> Pediatric Associates or <input type="checkbox"/> _____ Organization / Person	_____
Street Address _____	City, State, Zip _____	Street Address _____	City, State, Zip _____
Phone _____	Fax# _____	Phone _____	Fax# _____

### INFORMATION TO BE RELEASED

PA Health Records     Entire Record     PA Billing Record

Other (please specify) \_\_\_\_\_

Format for records (please check ONLY one box):  MAIL                       FAX                       PICK UP

### PURPOSE OF RELEASE

Legal                       Personal use                       Continuing Care                       Transfer to another provider                       School

Other \_\_\_\_\_

### AUTHORIZATION FOR GENERAL RELEASE OF INFORMATION

#### I understand that:

- Authorizing the disclosure of this healthcare information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can cancel this authorization at any time by written notification to Pediatric Associates. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further releases or distribution by the recipient that may not be protected by confidentiality laws.

This authorization will expire 90 days from the date signed below unless another date or event is entered here \_\_\_\_\_.

(Note: If the disclosure is to another employer or financial institution, this authorization will expire 90 days from the date signed by you.)

**Sensitive Records may require specific patient authorization, please check the applicable box below to request the following records.**

Drug/Alcohol abuse/treatment & diagnosis     Sexually transmitted diseases     Mental Health Treatment

HIV/AIDS diagnosis/treatment/testing

### SIGNATURE OF MINOR PATIENT REQUESTED FOR THE FOLLOWING RECORDS

A minor patient's signature is required to release the following information: 1) Information related to reproductive care such as birth control, pregnancy-related services and Sexually Transmitted Diseases, including HIV/AIDS (age 14 and older); 2) Substance abuse and mental health treatment (age 13 and older).

Signature of Minor Patient \_\_\_\_\_

Date \_\_\_\_\_

### SIGNATURE OF PATIENT / LEGAL REPRESENTATIVE

Signature of Patient or Legally Responsible Party \_\_\_\_\_

Date \_\_\_\_\_

Relationship to patient, if not signed by patient \_\_\_\_\_

Revised 07/21/2016