



Pediatric Associates

OF DALLAS

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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