



# Pediatric Associates OF DALLAS

Woodhill Medical Park, 8355 Walnut Hill Lane, Suite 200, Dallas, Texas 75231  
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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			
<input type="checkbox"/> PA Health Records	<input type="checkbox"/> Entire Record	<input type="checkbox"/> PA Billing Record	
<input type="checkbox"/> Other (please specify) _____			
<b>Format for records</b> (please check ONLY one box): <input type="checkbox"/> MAIL <input type="checkbox"/> FAX <input type="checkbox"/> PICK UP			

PURPOSE OF RELEASE				
<input type="checkbox"/> Legal	<input type="checkbox"/> Personal use	<input type="checkbox"/> Continuing Care	<input type="checkbox"/> Transfer to another provider	<input type="checkbox"/> School
<input type="checkbox"/> 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 01/01/2014