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:
❑ Pediatric Associates or ❑ _____ Organization / Person	❑ Pediatric Associates or ❑ _____ 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