

**Pediatric Associates**

**OF DALLAS**

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 first 20 pages and .50¢ each page after.*

*(Revised 6/28/2023)*

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 of Dallas | □ Pediatric Associates of Dallas |
| Organization / Person | 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 □ PICK UP □FAX □EMAIL

For mail or pickup only:

□ USB Drive

□ Legal

# PURPOSE OF RELEASE

□ Personal use □ Continuing Care □Transfer to another provider □ School

**Please Explain:**

# 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 09/23/2022