Pediatric Associates of Plano
6130 W. Parker Rd. #410
Plano, Texas 75093
972-981-8380 fax 972-981-8463

Release of Medical Records

Patient Name (Print):_____ Patient DOB _____

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Patient Name (Print): _____ Patient DOB _____

If leaving our practice please choose one of the following: □ Moving Out of State □ Insurance Reasons □ Age of Patient
□ Other Reason (please Specify):
_____
_____ I authorize Pediatric Associates of Plano (information above) to **obtain** my medical records from the following facility/ doctor:
_____ I authorize Pediatric Associates of Plano (information above) to **forward** my medical records to the following facility/ doctor:
Doctor/ Facility Name:_____

Address:_____

Phone:_____Fax:_____

Please identify the information to use, release, obtain or disclose (you must choose at least one item):
□ **Please release my entire record**

□ Please release ***only*** the following information (check appropriate boxes and include other information where indicated):
□ Allergy List □ Lab Results (Please describe the dates or types of lab tests you would like
□ Immunization Records disclosed):
□ Medication List _____
□ Most Recent History
□ Problem List _____

□ Other (Please describe):
_____
The identified information will be used for the following purpose:
□ My Personal Records □ Sharing with other Health Care Providers as needed
□ Other (Please Describe):
_____
_____ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
_____ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
_____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
_____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.
This authorization will expire on (insert date or event):
If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

_____ _____
Patient Signature (or Signature of Person Completing Form if Not Patient) Date
Relationship to Patient □ Parent □ Legal Guardian □ Other:

_____ _____
Witness Signature Date