



AUTHORIZATION TO RELEASE/DISCUSS INCOMING HEALTHCARE INFORMATION

Patient Name: _____ DOB: _____

I, _____, residing at _____
(name) (address)
authorize release of information from: _____

Address: _____

Information to be released/discussed to: **Pecan Tree Pediatrics**
1005 West Ralph Hall Parkway, Suite 135
Rockwall, Texas 75032
FAX: 214-520-7120
Phone: 972-772-3100

PURPOSE OF RELEASE (please check one):

Changing Physicians (reason for transfer) _____ Legal Other _____

Although it will be requested, I understand confidentiality at the receiving end cannot be guaranteed.

TYPE OF INFORMATION TO BE RELEASED:

- General Medical Records - excluding protected material
- Specific Information Only: _____
- Other Practitioners Records
- Other: _____

PROTECTED OR SENSITIVE INFORMATION:

I understand that certain information cannot be released without specific authorization as required by law.

By initialing, I authorize release of the following protected information:

- ___ Mental Health Information:
- ___ Drug Abuse/Alcoholism Information
- ___ AIDS/HIV Test results- including high risk behavior
- ___ Other sexual information such as dysfunction or related diseases

I UNDERSTAND THAT:

**I can revoke my consent at any time prior to the release of records by delivering a written, signed and dated notice of my wish to Pecan Tree Pediatrics.

**I can refuse to disclose some or all of my records, but if I do so, it could result in any improper diagnosis or treatment, denial of coverage of a claim for health benefits or other adverse consequences. Incomplete records may be labeled to inform the receiving of their status.

**I can edit and/or obtain a copy of this release upon request.

Signature of Parent/Guardian or Authorized Representative

Date