



# AUTHORIZATION TO RELEASE/DISCUSS OUTGOING HEALTHCARE INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone: \_\_\_\_\_

I, \_\_\_\_\_, residing at \_\_\_\_\_  
(name) (address)

authorize release of information from: **Pecan Tree Pediatrics**  
**1005 West Ralph Hall Parkway, Suite 135**  
**Rockwall, Texas 75032**  
**FAX: 214-520-7120**  
**Phone: 972-772-3100**

Information to be released/discussed to: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**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