AUTHORIZATION TO RELEASE/DISCUSS HEALTHCARE INFORMATION

Patient Name: _____ **DOB:** _____

Phone: _____

I, _____, authorize release of information from:

Pecan Tree Pediatrics
FAX: 972-692-1128

1005 West Ralph Hall Parkway, Suite 135
Rockwall, Texas 75032
Phone: 972-772-3100

3360 West FM 544, Suite 910
Wylie, Texas 75098
Phone: 972-429-4800

Information to be released/discussed to: _____

Address: _____

_____

Phone: _____ Fax: _____

PURPOSE OF RELEASE (please check one):

☐ Changing Physicians ☐ Legal ☐ Other _____

Although it will be requested, I understand confidentiality at the receiving end cannot be guaranteed.
Transfers to another metroplex practice will not be allowed to return to Pecan Tree Pediatrics.

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 if this release upon request.

_____ _____

Signature of Parent/Guardian or Authorized Representative Date