AUTHORIZATION TO RELEASE/DISCUSS *INCOMING* HEALTHCARE INFORMATION

Patient Name: _____ **DOB:**_____

I, _____,
(name)
authorize release of information from Clinic / Name of Physician:
_____

Address: _____

_____

Phone: _____ Fax: _____

Information to be released/discussed to: ***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

Records can be faxed or mailed to either location.

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.

TYPE OF INFORMATION TO BE RELEASED:
☐ General Medical Records - excluding protected material
PLEASE INCLUDE GROWTH CHARTS AND IMMUNIZATION RECORDS, AS WELL AS GENERAL NOTES
☐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