PECAN TREE PEDIATRICS

# AUTHORIZATION FOR **RELEASE** OF **OUTGOING** MEDICAL INFORMATION

I hereby authorize Pecan Tree Pediatrics to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary, and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g., insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

I understand that this authorization will expire 90 days from the date of signature or at the date or event specified here. _____(Expiration date/event).

I further understand that I may revoke this authorization at any time by notifying, in writing, Pecan Tree Pediatrics facility where this authorization is being signed and approved. I also understand the revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any releases made prior to the receipt of the written revocation.

I understand there is a charge for medical records provided, as permitted by Texas law, unless copies are sent directly to another health care provider.

| Patient Name | Last 4 of Social Security Number | Date of Birth | Chart # (Completed by Pecan Tree Staff) |
|---|---|---|---|
| | | MM / DD YYYY | |
| Street Address City, State, Zip | | Telephone Number | |

**Please release medical information for treatment dates**: □ ALL Dates OR □ Specific Date Range: _____

The information will be **RELEASED TO:** □ Patient/Designee □ Health Care Facility □ Insurance Company □ Attorney □ Other

| Individual/Organization Name | | Telephone Number |
|---|---|---|
| Street Address | City, State, Zip | Fax Number |

**Purpose of the use and/or disclosure:** □ Continued Care □ Legal □ Insurance □ Personal Use □ Other _____

**Record copy delivery:** □ Pick-up □ Mail □ Fax to Healthcare Office □ Electronic/Email _____
(Used for access password and/or records file)

**Information to be released:**

□ **COMPLETE Patient Chart** or Specific Information Only (select below)

□ Well Child Summary □ Sick Encounter Summary □ Immunization Records □ Growth Charts

□ Diagnostic Results □ Medications □ 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
____*Not Applicable*

I understand the record might not be complete, if it is a recent visit, and additional documentation could be added after submitting this request.

By entering my name below, I certify that this information can be used for the purpose of processing my/my child's Authorization for Release of Information request. I consider this as my authorization signature for this request.

_____ _____
Signature of Patient/Legal Guardian/Representative Date

_____ _____ _____
Printed Name of Patient/Legal Guardian/Representative Relationship to Patient Valid Government ID # (DL, passport, etc)