PECAN TREE PEDIATRICS

AUTHORIZATION FOR **RELEASE** OF **INCOMING** MEDICAL INFORMATION

I hereby authorize Pecan Tree Pediatrics to obtain my individually identifiable health information as authorized 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 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.

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: _____

I authorize release of information *from*:

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 _____

Information to be released:

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

□ Well Child Summary □ Sick Encounter Summary □ Immunization Records

□ Diagnostic Results □ Growth Charts □ Phone Messages

□ 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*

The information will be **RELEASED TO:** ***Pecan Tree Pediatrics***

All Locations - ***Email:*** ***records@ptpeds.com*** *OR* ***Fax: 469-757-4890***

MAIL ALL RECORDS TO ROCKWALL LOCATION

Lakewood	***Rockwall***	***Wylie***
6301 Gaston Avenue, Suite 750	*201 I-30 East, Suite 100*	*3360 W FM 544, Suite 910*
Dallas, Texas 75214	*Rockwall, Texas 75087*	*Wylie, Texas 75098*
(214) 214-3100	*(972) 772-3100*	*(972) 429-4800*

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)