AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

Please REQUEST medical information FROM:

Primary Care Provider:

_____

Village Pediatrics
5425 West Spring Creek Parkway
Suite 175
Plano TX 75024
Phone # 214-473-2200
Fax #214-473-2201

Please SEND medical information TO:

Clinic/Physician:_____

Address:_____

City:_____State:_____Zip:_____

Phone:_____

Fax:_____

I hereby authorize the above-mentioned provider to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above. I also understand this information may contain information relating to Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV), mental health, and alcohol and /or drug abuse.

Release and/or disclose records and information regarding:

_____ _____-_____- _____ _____/_____/ _____
Name of Patient Social Security Number Date of Birth

_____ _____ _____ _____
Address City State Zip Code

_____ _____ _____
Home Work Cell

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for ninety days from the date of signature if no date entered.
REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.
REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

PLEASE SPECIFY RECORDS TO BE RELEASED AND/OR DISCLOSED:
CD or electronic version is preferred.

_____Entire medical records_____History and Physical_____Chart Summary_____Labs_____Radiology_____ Pathology
_____Other (please specify) _____

I request that the health information release and/or disclosed pursuant to this authorization be used for the following purposes only:
_____Physician or Health Care Facility_____Legal_____Personal_____Other (please specify) _____

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization. The copy is for me to keep. I understand that there may be a fee for preparing and furnishing this information.

_____ _____ _____
Signature of patient or legal representative Date Relationship if not patient