REQUEST FOR RELEASE OF INFORMATION

Information regarding patient for whom authorization is made:

Full Name: _____

Other Name(s) Used: _____ Date of Birth: _____

Address:_____ City:_____ State:_____ Zip Code:_____

Phone: (_____)_____ Email (*Optional*): _____

Information regarding health care provider or health care entity authorized to disclose this information:

Name: _____

Address:_____City:_____ State:_____ Zip Code:_____

Phone: (_____)_____ Fax: (_____)_____

Information regarding person or entity who can receive and use this information:

Name: Trophy Club Pediatrics PA/ TCP

Address 2213 Martin Drive, Ste 200 Bedford TX 76021

Phone: **817-400-1572** Fax: 855-298-3967

Specific information to be disclosed:

□ Medical Record from (insert date) _____ to (insert date) _____

□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.

□ Other: _____

Include: (*Indicate by Initialing*)

_____ Drug, Alcohol or Substance Abuse Records

_____ Mental Health Records (Except Psychotherapy Notes)

_____ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)

_____Genetic Information (Including Genetic Test Results)

Reason for release of information:

(Choose all that Apply)

□ Treatment/Continuing Medical Care

□ Personal Use □ School

□ Billing or Claims □ Employment

□ Insurance □ Disability Determination

□ Legal Purposes

□ Other*(Specify)*: _____

The individual signing this form agrees and acknowledges as follows:

(I) **Voluntary Authorization:**This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: Month: _____ Day: _____ Year: _____.

(iii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv) **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(v) **Signature Authorization:**I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:

Patient/Legal Representative: _____Date:_____

If Legal Representative, relationship to Patient_____

Witness (optional): _____Date: _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable): _____ Date: _____