

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I understand that my child(s) medical records are confidential and cannot be disclosed without my written authorization, except otherwise provided for by law. I hereby voluntarily authorize TOTS 2 TEENS.

(Patient Name)

(DOB)

The information specified below may be released to:

TOTS 2 TEENS
3626 N. MacArthur Blvd. Ste 200
Irving, TX 75062
972-256-2028 Fax: 972-570-5672

The information specified below may be released by:

Name: _____
Address: _____ City: _____
Zip Code: _____ Telephone#: _____ Fax: _____

The specific purpose(s) for this disclosure is/are:

- my personal use
- sharing with other healthcare providers
- other (please describe) _____

I WANT I DO NOT WANT (Please check one) you to INCLUDE information pertaining to the diagnosis and/ or treatment of HIV testing, AIDS, psychiatric illness, and alcohol and/ or chemical and dependency if any.

SPECIFIC INFORMATION TO BE RELEASED: (Please check all that you are requesting to be released)

_____ Complete Medical Records for this Office _____ Immunization Records Only
_____ History & Physical _____ Diagnostic Testing & Results
_____ Other (Please List) _____

- I understand that I may revoke this authorization at any time by notifying the office in writing at **ATTN: Practice Manager, Medical Record Request**, of my intent to revoke this authorization, and that such revocation will not have any effect on any actions taken by the office before revocation
- I understand this authorization **expires 180 days** from the date signed, unless otherwise revoked.
- I understand that once the above information may not be protected by federal privacy laws or regulations.
- I understand that **I may be charged for the copies** of my child’s medical record, which I request for myself or for the use by others. I also understand **fees for copies are due and payable before copies are released.**
- I understand that a photocopy or facsimile of this authorization is as valid as the original.

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____