AUTHORIZATION TO RELEASE/DISCUSS HEALTHCARE INFORMATION

Poole Pediatrics, P.A.
INFANTS THROUGH TEENS

Patient's Name_____ DOB: _____

Patient's Name_____ DOB: _____

I, _____, residing at _____
(parent's name) (address)

authorize release of information from: _____
(previous physician's name)

Address: _____Phone #_____

_____ Fax # _____

Information to be discussed/released to: ***POOLE PEDIATRICS, P.A.***
3601 North Star Rd.
Richardson, Texas 75082
Ph # 214-343-0818
Fax # 214-343-3410

PURPOSE OF RELEASE (please check one)
____Changing Physicians-reason for transfer_____ ____ Legal ____ Other_____
(Although it will be requested, I understand confidentiality at the receiving end cannot be guaranteed.)

TYPE OF INFORMATION TO BE RELEASED:
____Specific Information only: _____
____General Medical Records- excluding protected material
____ Other practitioners records (Who's?)_____
____ 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

I UNDERSTAND THAT:
** I can revoke my consent at any time prior to the release of records by delivering a written, signed and dated notice of my wish to Poole Pediatrics, P.A.
**I can refuse to disclose some or all of my records, but if I do so, it could result in an improper diagnosis or treatment, denial of coverage of a claim for health benefits or other adverse consequences. Incomplete records may be labeled to inform the receiver of their status.
**I can edit and/or obtain a copy of this release upon request.

_____ Date_____
Signature of Parent/Guardian or Authorized Representative

This authorization will expire one year from date signed.