

Pediatric & Adolescent Specialists of Rockwall
890 Rockwall Pkwy., Ste. 100, Rockwall, TX 75032
(214)771-3712 Fax (214)771-3796

AUTHORIZATION TO OBTAIN HEALTH INFORMATION

I, the undersigned, hereby authorize the disclosure or access of confidential health information from the medical record of the below-named patient.

Patient Name _____ Date of Birth _____ SS# _____
Address _____ City _____ State _____ Zip _____

PATIENT INFORMATION IS NEEDED FOR: Please select one option

- Changing Providers/Continuing Medical Care Military Personal Use School/Daycare Insurance
 Legal Purposes Social Security/Disability Other: _____

DATE(S) OF TREATMENT: _____ All Dates of Treatment

INFORMATION TO BE RELEASED OR ACCESSED:

- Clinic Notes Consultation Report Immunizations All Records
 Procedure Notes EKG Reports Medication/Prescription List
 Lab/Pathology Reports Radiology Reports Problem List
 Behavioral Health Radiology Images Other _____

I authorize _____ Address _____

City _____ State _____ Zip _____ Phone _____ Fax _____

to release above specified confidential medical information to PASR/Gregory Sonnen, MD,FAAP, Rana Pascoe, MD,FAAFP and/or Christopher Becker, MD for the purpose of Patient Care.

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged a retrieval/processing fee and for copies of my medical records according to Texas Hospital Licensing law.

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition as follows: _____.

Signature of Patient or Legal Representative

Date

Printed Name of Patient or Legal Representative

Relationship to Patient

For Department Use: MRN/Acct #
