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

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

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

Patient Name_____ Date of Birth _____ SS#_____

Address_____City_____State_____ Zip_____

Phone/Contact Number _____

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 _____

METHOD OF DELIVERY:

☐ Pick Up (You will be notified via a telephone call when records are ready for pick up)
☐ Mail to Address listed below
☐ Fax (**Not an option if requesting entire medical records**; only applicable for vaccine records or specific report(s))

I authorize Dr. Sonnen, MD,FAAP, Dr. Pascoe, MD, FAAFP, or Dr. Becker, MD to release the above information to:

_____
(Name)

_____
Address (Street, State, Zip Code) Phone Number Fax Number

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 #

_____

Revised 06/17