AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

NAME OF PATIENT

(Last) (First) (Middle)

DATE OF BIRTH

ADDRESS

CITY STATE ZIP

I am the parent / legal guardian of the patient above. **I hereby authorize the following to disclose my child's medical record and protected health information** in accordance with the instructions. I understand that medical records may contain information relating to acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services.

Yes, I consent **No, I do not wish to consent to release of this sensitive information**

I understand that I have the right to revoke this authorization at any time by giving written notice present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to insurance companies when the law provides my insurer with the right to contest a claim under my policy. **I authorize disclosure of my child's medical records and protected health information as indicated below**

TO **FROM**

CARE AND CURE PEDIATRICS
1121 Kinwest Pkwy, Unit 150, Irving, TX 75063
Phone: (972) 893-1192 | Fax: (972) 793-0924

FROM **TO**

Phone **Fax**

Please release the following items: **COMPLETE MEDICAL RECORD**

HOSPITAL ASSESSMENT & DISCHARGE SUMMARY MOST RECENT H&P

DIAGNOSTIC TESTS & LAB REPORTS

The reason for release of information is: **Continued Medical Care** Legal

Other

Unless otherwise revoked, this authorization expires upon completion of this request or upon the following: I desire this authorization stay in effect until: . I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR-164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about this disclosure of my health information, I can contact Care and Cure Pediatrics.

Signature of Parent / Legal Guardian

Full Name of Parent / Legal Guardian

Relationship to Patient

Drivers ID # of Parent / Legal Guardian

Date