ELITE PEDIATRICS
137 ZAMORA MEDICAL CIRCLE
EAGLE PASS, TX 78852
PH: 830-758-7621
FAX: 1-877-515-3109

Medical Records Release Authorization form

PATIENT'S NAME _____ D.O.B. _____/_____/_____

PARENT/GUARDIAN_____
(Relationship) (Phone #)

I hereby give _____ (name of doctor or facility) permission to release all records as indicated below, to _____ (name of doctor or facility, or self).

Release Records to the following Person(s) or Organizations:
Name: _____
Address: _____
Phone: _____
Email: _____

These records will be released for the purpose of:
☐ Patient Care ☐ Specialist ☐ Attorney/Client ☐ Insurance
☐ School ☐ Changing Practices ☐ Moving
☐ Personal Use ☐ Other: _____

The records to be released will include:
☐ Entire Medical Record **including** diagnoses and treatment of mental health, alcohol or drug abuse records, and HIV/AIDS records.
☐ Entire Medical Record **excluding** diagnoses and treatment of mental health, alcohol or drug abuse records, and HIV/AIDS records.

To be disclosed the following items must be specifically checked.
☐ Behavioral and/or mental health records
☐ Drug/alcohol diagnosis, treatment, and/or referral information
☐ HIV/AIDS related health information and/or records
☐ Information about sexually transmitted disease
☐ Pregnancy records
☐ Birth control records

If this patient is 12 years old or older, the patient must also authorize the release of this information.
☐ Entire record, including items listed above.

_____
Patient Signature (If 12 years or older)

☐ **Please release only the following:**
☐ Immunization Records ☐ Growth Charts ☐ Medication List ☐ Lab Results ☐ Imaging Results ☐ Other: _____

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.
*I understand t*hat the practice may not condition treatment on whether I sign this authorization, except when the provision of healthcare is solely for the purpose of creating protected health information for disclosure to a third party.
I understand that this authorization is valid for one full year unless a written letter of termination is received.
I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office. Absent such revocation, the Authorization for Release of Confidential Health Information will terminate on (date) _____/_____/_____.

I understand that there is a fee per chart for these records and will pay at the time of the request. I also understand that once the medical records are released for the purpose of switching physicians or seeking other medical care, that I am only able to receive emergent care from ELITE PEDIATRICS for 30 days and I am responsible for seeking medical treatment elsewhere thereafter.

_____ _____ _____/_____/_____
Signature of Parent/Legal Guardian Relationship Date

For office use only

Received: _____ ____/____/____ Paid: _____ ___/___/____ Approved: _____/____/____
Entered: _____ ____/____/____ Paid amount: _____ Confirmation receipt: __/____/____
Mailed: _____ ____/____/___ Balance/records$_____/____ Upcoming appt/fax/address validated ___/____/____