SACHSE PEDIATRICS

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:
Patient Name _____Date of Birth_____
Social Security #_____ (optional)

I authorize the following individual or organization to disclose the above named individual(s) health information:
Name _____
Address_____
City/ State/Zip_____
Phone # _____Fax#_____

This information may be disclosed TO and used by the following individual or organization:
SACHSE PEDIATRICS
4650 President George Bush TPK #108
Sachse, Texas 75048

Please release the following:
___Entire Record
Or: ___Newborn Hospital Assessment Record ___Laboratory Results ___X-Rays
___EKG Report ___EEG Reports ___Operative Reports
___Therapy Reports ___Obstetrical Reports ___Psychological Reports
___Most Recent History and Physical ___Other (specify) _____

Purpose for the release:
___Medical Care ___Insurance Purpose ___Legal Purpose ___Other:_____

I understand that my medical record 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 consent to the release of this information**

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and 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 my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date:_____

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 in order 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 Sachse Pediatrics.

_____ DL# _____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient Witness