Alliance Pediatrics

AUTHORIZATION TO RELEASE RECORDS (6-2020)

_____ _____

Name of Patient *Patient's Date of Birth*

I am the parent or legal guardian of the above-named minor child. I authorize _____ and request the release of information to include protected health information, from my child's medical record, in accordance with these 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 the release of this sensitive information

I understand that I have the 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 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 as indicated below:

The health information described shall be released ☐ *TO* *or* ☐ *FROM (check one)* the following Alliance Pediatrics location:

☐ Alliance Pediatrics-Woodland Springs
12461 Timberland Blvd. Ste. 309
Fort Worth, TX 76244
Office: 817-741-5437
Fax: 817-431-5870

☐ Alliance Pediatrics-Heritage Trace
9445 North Beach Street
Fort Worth, TX 76244
Office: 817-741-5437
Fax: 817-431-5870

The health information described shall be released ☐ *TO* *or* ☐ *FROM (check one)* the following individual or organization:

Name: Address

Phone: Fax:

Please release the following:

☐ **Complete Medical Record** **OR:** ☐ Newborn Hospital Assessment Record ☐ EKG Report ☐ Most Recent H & P

☐ Laboratory Results ☐ Billing Records ☐ Behavioral/Mental Health ☐ Other _____

The reason or purpose for the release of information is:

☐ Continued Medical Care ☐ Insurance Use ☐ Legal Use ☐ 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 Alliance Pediatrics.

_____ _____ _____

Signature of Parent or Legal Representative *Driver's License #* *Relationship to Patient*

_____ _____ _____

Printed Name of Parent or Legal Representative *Witness* *Date* *(8/8/24 v1.8c)*