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## Authorization for Release of Information

Printed Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Phone Number(s): \_\_\_\_\_

I hereby authorize Pediatricians of Dallas to release the information specified below from the medical record(s) of the above named patient.

Recipient of Records: \_\_\_\_\_

Address, City, State, Zip Code: \_\_\_\_\_

Phone Number of: \_\_\_\_\_ Fax #: \_\_\_\_\_

OR

I hereby authorize \_\_\_\_\_ to release the information specified below from the medical record(s) of the above named patient.

Recipient of Records: \_\_\_\_\_

Address, City, State, Zip Code: \_\_\_\_\_

Phone Number of: \_\_\_\_\_ Fax #: \_\_\_\_\_

Date of Service: From: \_\_\_\_\_ to \_\_\_\_\_ . Requested information is needed for:

Changing Doctors  Continuing Medical Care  Personal Use  Other \_\_\_\_\_

The Patient/Responsible Party's express authorization is required to release certain types of records, including alcohol and/or drug abuse treatment and information, communicable diseases, HIV testing and treatment, psychiatric treatment, and genetic testing. To authorize release of this information, please read and initial the information to be released.

I authorize the release of **alcohol and/or drug abuse** treatment and information. \_\_\_\_\_ Patient/Responsible Party Initials

I authorize the release of **HIV test results** and/or HIV treatment information. \_\_\_\_\_ Patient/Responsible Party Initials

I authorize the release of **psychiatric** information. \_\_\_\_\_ Patient/Responsible Party Initials

I authorize the release of **genetic** testing information. \_\_\_\_\_ Patient/Responsible Party Initials

I understand I may revoke this authorization in writing at any time, except to the extent that POD has relied on this authorization. The written revocation should be addressed to the above letterhead address. Unless otherwise revoked, I understand this authorization expires in Ninety (90) days from the date of signature. A copy of this authorization is considered as valid as the original. I understand the recipient authorized to receive the health information may not be a covered entity (e.g. non-health care provider) and the released information may be redisclosed and may no longer be protected by federal and state privacy regulations.

\_\_\_\_\_  
Patient/Responsible Party Signature

\_\_\_\_\_  
Patient/Responsible Party Printed Name

\_\_\_\_\_  
Date

Relationship to Patient: \_\_\_\_\_