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Robyn M Lilly, CPNP-PC • Amanda Bodwell, CPNP • Ashley London, CPNP-PC/AC

Authorization for Release of Information

Printed Patient Name: _____ Date of Birth: _____

Address: _____ City: _____

Zip Code: _____ Phone Number(s): _____

RECORDS *LEAVING* PEDIATRICIANS OF DALLAS [ ] 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

RECORDS *BEING SENT TO PEDIATRICIANS OF DALLAS*

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

Previous Physician's 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: _____ Revision Date: 03/29/2017