www.pediatriciansofdalias.com
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**** Fees for medical records may apply. Please do not fax any record over 25 pages****

Authorization for Release of Information

Please email this signed form to records@pod.pcc.com

Fax up to 25 pages to 214-691-0404 and Email over 25 pages to records@pod.pcc.com

Printed Patient Name: _____ Patient Date of Birth: _____

Address:_____ City: _____ Zip Code:_____

Phone Number: _____

RECORDS LEAVING PEDIATRICIANS OF DALLAS [ ] I hereby authorize **Pediatricians of Dallas** to release the information specified below from the medical record(s) or the above names patient.

Recipient of Records: _____

Address, City, State, Zip Code: _____

Phone number: _____ 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: _____ Fax#: _____

Date of Service: From: _____ to _____

Requested information is needed for: [ ] Changing Doctors [ ] Continuing Medical Care [ ] Personal Use [ ] Other: _____

Sending option: __ Mail (CD / Paper) __ Email __ Fax

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, psychiatric treatment, and genetic testing. To authorize release of 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 the 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 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**