# AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

**Patient Name:** _____

**Home Address:** _____

**Date of Birth:** _____ **Social Security No.:** _____-_____-_____

**SPECIFY INFORMATION TO BE DISCLOSED** (i.e. all medical records, specific test results, specific date range):

_____

**RECIPIENT** (Name of person(s) to whom protected health information may be disclosed): _____

_____

**PURPOSE FOR DISCLOSURE** (i.e. personal use, treatment, individual request, etc.): _____

_____

Please mark below if you specifically authorize the release of the following types of protected health information.

- □ Sexually Transmitted Disease (STD)
- □ AIDS/HIV
- □ Genetic Information
- □ Behavioral or mental health services
- □ Alcohol or substance abuse
- □ Child Abuse/Domestic Abuse

Pursuant to HIPAA Privacy Rules, I/authorized representative acknowledge the right to revoke this authorization at any time. It is understood that revocation of this authorization must be done in writing and presented to the healthcare provider named above; the revocation will not apply to information that has already been released in response to this authorization. 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.

I/authorized representative understand that:

- Authorizing the disclosure of health information is voluntary.
- Refusal to sign this authorization will not delay treatment.
- Any disclosure of information carries with it the potential for an unauthorized re-disclosure.
- There may be a fee for copying, mailing or other supplies associated with this request.
- I understand that I/authorized representative have a right to receive a copy of this signed authorization.
- Authorization shall not expire.

_____ _____
Print Name of Patient/Parent/Authorized Representative Date

_____ _____
Signature of Patient/Parent/Authorized Representative Relationship to Patient

_____ _____
Witness Date

_____ _____
PARENT/GARDIAN PHONE # CURRENT PCP FAX NUMBER

PEDIATRIX TOTS CLINIC
712 N WASHINGTON AVE. STE. 510
DALLAS, TX 75246
PHONE 214.827.7081 FAX 214.827.1507