



RELEASE OF OF MEDICAL INFORMATION

Patient's legal name _____ DOB _____
Patient's legal name _____ DOB _____
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Patient's legal name _____ DOB _____

I hereby authorize the physician below to disclose copies of the medical record information and/or protected health information to the patient (s) listed above to All Star Pediatrics

Physician name: _____ Phone Number: _____

Fax Number: _____

Specific Record requested:

<input type="checkbox"/> Emergency Department	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Laboratory
<input type="checkbox"/> History and Physical	<input type="checkbox"/> Physician Orders	<input type="checkbox"/> Face Sheets
<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Radiology Reports
<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Immunization Records	<input type="checkbox"/> Pathology Reports

Expiration: This authorization shall expire on the 180th day after it is signed, unless as provided otherwise upon the expiration date.

- I understand that I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any action taken prior to the health care facility receiving the revocation. Further details may be found in the Notice of Privacy Practices for All Star Pediatrics.
- If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
- Copy fees/charges will comply with the Texas Health and Safety Code, Chapter 241 and all other laws and regulations applicable to release of information.
- I understand that treatment and payment are not a condition of signing this authorization. Upon request, I may receive a copy of this form after I have signed it.
- I have read the above and authorize the disclosure of the protected health information as stated.

Patient/Parent/Guardian Signature: _____ Date: _____

Please FAX all medical record information to:

All Star Pediatrics 214-872-3114

2875 West Main Street, Suite 104 Frisco, TX 75034 214-872-1877