AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

(From All Star Pediatrics to a specified provider or parent)

Patient name: _____ DOB: _____

Patient name: _____ DOB: _____

Patient name: _____ DOB: _____

Address _____ City _____ Zip _____

Phone Number: _____ Parent Email: _____

I hereby authorize All Star Pediatrics to disclose copies of the medical record information and/or protected health information of the patient listed above to:

Dr. _____ at _____
(address or fax)

OR to parent(s)

_____
(names of parents or guardians)

Reason for Transfer: _____

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.
- *** There will be a $25 charge added to my account for HARD COPIES of records over 25 pages.

I have read the above and authorize the disclosure of the protected health information as stated.

Parent/Guardian Signature: _____ Date: _____