**Authorization for Release of Medical Information**

**from Pediatric Associates of Wylie, P.A.**

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**Patient’s Name DOB: MM/DD/YYYY**

Records to be released from:

**Pediatric Associates of Wylie, P.A.**

501 Woodbridge Parkway

Wylie, TX 75098

972-442-2300 Fax: 972-442-2180

**I hereby authorize the above stated physician/facility to release the following information:**

* Immunization Records
* Records between these dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
* All Records MM/DD/YYYY MM/DD/YYYY
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **HIV/AIDS:** I consent to the release of any positive or negative test result for AIDS OR HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.  **Initial:\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Records Released To:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name of Person or Organization Information is released to**.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_**

Address City State Zip

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Phone Number Fax Number

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Signature of Parent/Legal Guardian Printed Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient Date

**Acknowledgement of Understanding**

This Authorization will expire 90 days after the date identified above. I understand that I may revoke this authorization at any time in writing, and it will be effective on the date notified except to the extent action has already been taken. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations. I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care. I understand that the physician/facility you have requested records from has 15 days by law to send us the records.