Medical Records Release

I authorize Angel Pediatrics to release confidential health information by distributing a copy of medical records, or a summary or narrative of the protected health information, to the person(s) or entity listed in this form.

Patient Name: ____ **Date of Birth:** ____________________

(Last Name, First Name, MI)

Release the following health information:

☐Medical Chart ☐ Immunization Record ☐ Chart & Record ☐Other (describe)

____

Limit the release of information subject to this Release Form as follows:

☐None ☐One Time Use Only ☐Limit As Indicated

____

The reason(s) for this release of information:

☐Moving Out of Area ☐Transferring Care Locally ☐Other (describe)

____

This authorization shall be in force and effective until the following event and/or date: ____________________________

Release the protected health information to the following person(s)/entity:

Name:

Street:

City: **State:** **Zip:**

FAX: ______________________________ **Phone:** ____________________________

Disclosures

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

I understand that there will be a fee to copy medical records. $25 for the first 20 pages of medical records copied, $0.50 each additional page plus mailing cost. No charge for records sent to another physician.

I understand that additional information about this Medical Release is available in the Angel Pediatrics Notice of Privacy Practices. I understand that I can obtain a copy of the Notice in paper form or can visit the website (**www.angelpediatrics.com**) to review it on the Internet.

I understand that information disclosed because of this authorization may be divulged by the recipient to others and as such may no longer be protected by federal HIPAA privacy regulations.

I understand that Angel Pediatrics will not condition my treatment and payment on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the person listed below. I understand that a revocation is not effective to the extent that Angel Pediatrics has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Clinic Manager
Angel Peditarics
717 S Greenville Ave Ste 104 (972) 396-1900
Allen, TX 75002 (972)396-1901 FAX

____________________________________ ____________________________________
Signature of Patient or Personal Representative Name of Patient or Personal Representative

____________________________ ____________________________________
Date Relationship or Authority of Personal Representative