Children's Medical Clinics

1011 West Grove Street
Kaufman, Texas 75142-1883
972-932-1319
www.childrensmedicalclinics.net

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: ____ **DOB:** _______/_______/________

I hereby authorize: Childrenøs Medical Clinics
1011 W Grove Street
Kaufman, TX 75142

____ **TO OBTAIN CONFIDENTIAL INFORMATION FROM**

____ **TO RELEASE CONFIDENTIAL INFORMATION TO**

Name of Facility:____

Street Address: ____

Phone: (   ) ___________ - _________________   Fax: (   ) __________ - ________________

Purpose:
_______ Continuing Medical Care ______ School ______ Social Security ______ Personal Use

The following information will be released/obtained:

__ Entire Medical Record __ Vaccine Record __ History & Physical __ ADD/ADHD

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. I understand that the specified information to be release may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I have the right to refuse or to withdraw this authorization (withdrawal must be in writing). I also understand that this authorization will remain in effect for 180 days unless I specify an earlier expiration date here: ______..

Date: ______/______/_______

X______________________________________
Patient/Legal Representative's Signature

____
Relationship to child

____
Printed Name of Person Requesting Records