PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Kids Docs Pediatrics Associates to disclose certain protected health information about ______________________________.
Patient Name

This authorization permits Kids Docs Pediatric Associates to disclose the following individually identifiable information about ____________________________________.
Patient Name

There is **NO** charge for the following records:

_____ Immunization Records

_____ Summary of Visit History

_____ Statement of Charges/Payments

_____ Growth Chart

_____ Summary Diagnosis History

_____ Vision/Hearing Screens

There is a **$25.00** charge for any of the following records that is due and payable at the time this request is signed.

_____ Progress Notes

_______ Records from other doctors/facilities

_____ Lab/Xray Report

_____ Complete Chart

Please release medical records to the following:

Name: ____

Address: ____

City: ________________________ ST: ______ Zip: ____________

Fax # : ____________________________________

I do not have to sign this authorization in order to receive treatment from Kids Docs Pediatric Associates. In fact, I have the right to refuse to sign this authorization. When my information is used disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: 6200 W. Parker Rd # 400, Plano, TX 75093

Signed By:___________________________________ ____________________________
Signature of Patient or Legal Guardian Relationship to Patient

___________________________________ ____________________________
Patient Name Date