502 S. Old Orchard Ste 126
Lewisville, TX 75067
972.436.7962

**Authorization to Release Medical Records and Protected Health Information**

All information must be completed in full to validate this request. There is a $5 fee for shot records and a $25 fee for PediPlace medical records, due at time of release, except for the transfer to another licensed physician or for an agency administering disability or special benefits. **Request for records will be processed within 7 business days for current patients.**

**Patient Information:**

Patient Name: ___________________________________________ DOB: ____/____/____ Age: ________

Address: ____________________________________________

_____________________________________________________ Phone: ____________________

**Releasing Records From:**

Name: _______________________________

Address: _____________________________

_____________________________________

Phone: _________________Fax: _________

**Releasing Records To:**

Name: _______________________________

Address: _____________________________

_____________________________________

Phone: _________________Fax: _________

**Information to be covered by this release:**

| | | | |
|---|---|---|---|
| Entire Record | Lab/Pathology | Radiology/X-ray | Operative |
| Newborn/Neonatal | ER | Labor & Delivery | Shot Record |

Other ____________________________________________________________________________

*Note: The above information may include records we have on file from other physicians and/or health organizations.*

**Purpose for release:**

| | | |
|---|---|---|
| Relocating out of area | New insurance not accepted | Referral to specialist |
| Legal proceedings | Personal files | Other____________________ |

I, _______________________________, authorize the above listed entity and its employees to release for inspection and copying the Protected Health Information (PHI) specified above. I understand the records may contain information of a sensitive and confidential nature including but not limited to mental health, AIDS/HIV test information, and drug or alcohol treatment. I understand I may revoke this release at any time by notifying PediPlace in writing. I understand the potential for information to be disclosed following authorization is subject to redisclosure by the recipient and is no longer protected by HIPAA.

___________________________________________ ______________________________________

Parent/Guardian/Adult Patient's Signature Date

**(PATIENTS 18 YEARS AND OLDER MUST SIGN FOR RECORDS TO BE RELEASED)**