Children's Healthcare Associates, LLP

1301 S. Coulter, Suite 101 • Amarillo, TX 79106 • Phone 806-468-4350 • Fax 806-468-4351

Authorization for Release of Information

PATIENT'S NAME: _____ DOB: _____

ADDRESS: _____

I authorize and request that a copy of my medical records be released as follows:

Information to be released to:

_____
Name of Facility or Physician

_____
Address

_____
City, State and Zip Code

Information to be release from:

Children's Healthcare Associates, LLP
Name of Facility or Physician

1901 Medi Park Dr. Suite 200
Address

Amarillo, Texas 79106
City, State and Zip Code

INFORMATION TO BE RELEASED:

	DATES:
☐ History and physical exam	_____
☐ Progress notes	_____
☐ Lab reports	_____
☐ X-ray reports	_____
☐ Other: _____	_____
_____	_____

I specifically authorize the release of information relating to:

- ☐ Substance abuse (including alcohol/drug abuse)
- ☐ Mental health (including psychotherapy notes)
- ☐ HIV related information (AIDS related testing)

X _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

PURPOSE OF DISCLOSURE:
☐ Changes Physicians ☐ Consultation/second opinion ☐ Continuing care
☐ Legal ☐ School ☐ Insurance ☐ Workers Compensation
☐ Other (please specify): _____

1. I understand that this authorization will expire 60 days after I have signed the form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclose pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
4. By releasing this information I understand:
   a. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
   b. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.
5. If applicable, I understand that a fee may be charged in compliance with Texas statue. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

_____ _____
Signature of Patient, Parent, Legal Guardian Attorney Ad Litem, or Personal Representative — Date

_____
Please Print or Type Name