

Mansfield Pediatrics Medical Records Release Form

I hereby authorize my child's former physician:

Dr. _____
Address _____ City _____ State _____ Zip _____
Phone (____) _____ - _____ Fax (____) _____ - _____

To release the specified information below from the medical record of

Patient Name _____ Birth Date ____/____/____

Information may be released to the following party(s):

Mansfield Pediatrics
1825 Cannon Drive
Mansfield, TX 76063
(817) 453-7770 Fax (817) 453-7703
****We have EPIC EMR****
****NO CD'S PLEASE ****

INFORMATION OR MEDICAL RECORDS TO BE RELEASED BY MEANS OF THIS AUTHORIZATION INCLUDE THE FOLLOWING:

(list dates of admission and discharge or treatment)

<input type="checkbox"/> All Health Information	<input type="checkbox"/> Past/Present Medications	<input type="checkbox"/> Billing Information
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Diagnostic Testing & Results	<input type="checkbox"/> EKG/Cardiology Reports
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Radiology Report and Images	<input type="checkbox"/> Lab Results
<input type="checkbox"/> Operative Record & Pathology	<input type="checkbox"/> Physician's Orders	<input type="checkbox"/> Consultation Reports
<input type="checkbox"/> Patient Allergies	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Other

Initials are required to release the following information:

Mental Health Records (excluding psychotherapy notes) Genetic information (including Genetic test results)
 Drug, alcohol, or substance abuse records HIV/AIDS test results/treatment

Pursuant to the requirements of the Texas Medical Practice Act, please be advised that the purpose of reason for this release is as follows: (Choose only 1 option) Treatment/Continuing Medical Care Personal Use Billing or Claims
 Insurance Legal Purposes Disability Determination School Employment Other _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except otherwise provided for by law.

I also understand that records pertaining to the diagnosis and/or treatment of HIV testing, AIDS, psychiatric illness, alcohol or chemical dependency will not be released unless I have given my specific consent to release this information as indicated above.

I also understand that I may revoke this authorization at any time except that action has been taken in reliance upon it.

I understand that a photocopy or facsimile of this authorization is valid as the original.

Signature of Parent or Legal Guardian Date ____/____/____

Relationship to Patient

ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT(S) IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSE OF THIS DISCLOSURE.

#Confidentiality notice:

This message is intended only for the use of the individual or entity to which it is addressed and contains information that is legally privileged and confidential. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any use, dissemination, disclosure, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone at the number listed above.