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)

__All Health Information	__Past/Present Medications	__Billing Information
__History & Physical	__Diagnostic Testing & Results	__EKG/Cardiology Reports
__Discharge Summary	__Radiology Report and Images	__Lab Results
__Operative Record & Pathology	__Physician's Orders	__Consultation Reports
__Patient Allergies	__Progress Notes	__Other

Initials are required to release the following information:

__Mental Health Records (excluding psychotherapy notes)
__Drug, alcohol, or substance abuse records
__Genetic information (including Genetic test results)
__ 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.