Tots to Teens Pediatrics

Authorization to Release Medical Information

1. **I AUTHORIZE:**

_____
Name of Person/Organization

_____
Street Address

_____
City State Zip Code

_____ _____
Phone No. Fax No.

2. **TO RELEASE TO:**

Tots to Teens Pediatrics
619 W. F.M. 544 Suite 1B
Murphy TX.. 75094
Phone No. 972-424-7915
Fax No. 972-424-3652

2. **Patient Names and D.O.B**

_____

_____

_____

_____

INFORMATION TO BE RELEASED: (Check all Applicable)

All Information All Progress Notes Lab Reports X-ray Reports
Hospital Records Growth Chart Immunization Records Other:

3. **RECORDS FROM THE TIME PERIOD:** / / through / /

4**. PURPOSE OF DISCLOSURE** (may leave blank)_____

5. I understand that this authorization shall be valid for one year. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

6. I understand that the requester may not lawfully further use or disclose this health information unless another authorization is obtained from me or unless disclosure is required or permitted by law.

7. I understand that I may be provided with a copy of this authorization. I understand that this information will be provided within 15 business days of the request.

Parent's/Guardian Signature:_____ Date:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

For office use only:

_____
Initials of Staff Member Receiving Request Date