Seven Hills Pediatrics

6853 Coit Rd Suite 300
Phone: (469) 543-0630
Fax: (469) 543-0620

Authorization to Release Medical Records

Patient Name: _____

Patient Date of Birth: _____

Patient SSN: _____

I hereby authorize Seven Hills Pediatrics to: ___ disclose/release to ___ obtain from

To Doctor _____ **Phone #** _____

Address _____ **Fax#** _____

City, State, Zip Code _____

I, the undersigned, authorize you to furnish a copy of or allow the following medical records to be sent to the office of Dr. _____**.**

___ Entire Record **___ Most recent history and physical**
___ Immunization Record **___ Laboratory results Dates from** _____ **to** _____
___ Consultation reports **___ X-ray and/or imaging reports from** _____ **to** _____
___ Other

I understand that this authorization may include information relating to:
Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Syndrome (HIV) infection, Psychiatric Care, Behavioral or mental health services, treatment for alcohol and /or drug abuse and Genetic Testing

This authorization will expire on _____ **or 90 days from the date set forth below. In accordance with the procedures set forth in the Practice's Notice of Privacy Practices, when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice listed above has acted in reliance upon this authorization. My written revocation must be submitted in the practice above.**

_____ _____
Signature of Parent/Patient or Legal Guardian **Relationship**

_____ _____
Printed name of Parent, Patient or Legal Guardian **Date**

Purpose for disclosure _____