



McKinney ABC Pediatrics

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Authorization For Release of Medical Records

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

I hereby voluntarily authorize the release of the following information from the medical record of:

Patient(s) Name(s) Birth date(s)

The information specified below may be released to/from:

Name of physician: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Telephone: _____ Fax: _____

Specific information to be released: (Please check all that you are requesting be released)

____ Complete Medical Record for this Office _____ Immunization Records Only
____ Growth Chart Only _____ Diagnostic Testing & Results
____ Other (Please List) _____

[] I WANT [] I DO NOT WANT (please check one) you to INCLUDE information pertaining to the diagnosis and/or treatment of HIV testing, AIDS, psychiatric illness, and alcohol and/or chemical abuse and dependency if any.

- I understand fees for copies are due and payable before copies are released.
- I understand that a photocopy or facsimile of this authorization is as valid as the original.

Date Signature of Parent

Date Witness

Thank you in advance for sending this information promptly.

The personal health information that may be contained in this FAX is highly confidential. It is intended for the exclusive use of the addressee. It is to be used only to aid in providing specific healthcare services to this person. Any other use is a violation of Federal Law. Thank you for treating this information in a confidential manner.