Hilltop Pediatrics
300 North Highland Ave, Suite 542
Sherman, TX 75092

Authorization Form
For Release of Protected Health Information

1. Release information from the medical record of:

_____ _____ _____
Patient's Name – please print Date of Birth Social Security No.

_____ _____
Date of Treatment(s) Telephone Number

2. I hereby authorize _____ to release information to:
(sending entity)

_____
(receiving entity)

_____
(address of receiving entity)

3. Medical Records will not be released until they are complete. (Exception: Records required for continuation of care may be released to a designated caregiver prior to completion. Return Date of completed records (15 days).

4. Information to be released.

_____ Immunization Records _____ Laboratory Reports
_____ Entire Chart _____ Other: _____

5. I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. I understand that the specific information to be disclosed may include but is not limited to history of DRUG or ALCOHOL ABUSE, or MENTAL HEALTH TREATMENT, or information concerning communicable diseases such as HUMAN IMMUNODEFICIENCY VIRUS (HIV) and ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), and laboratory test results, treatment progress or any other such related information.

6. Patient information is needed for:

_____ Continuing Medical Care _____ Military _____ Social Security/ Disability
_____ Insurance _____ Personal Use Other: _____
_____ Legal Purposes _____ School _____

7. I understand that I may be asked to show proof that I have the authority to sign an authorization to review and/or receive copies of the above named patient's medical record which I am requesting.

8. I understand that I may revoke this authorization at any time by notifying the office in writing at ATTN: Practice Manager, Medical Record Request of my intent to revoke this authorization, and that such revocation will not have any effect on any actions taken by the office before revocation. This authorization will expire 180 days from the date of my signature or as otherwise specified by date, event or condition as follows:
_____

9. I further authorize that a photocopy of this authorization is acceptable as an original.

10. I understand that treatment, payment, enrollment, or eligibility for benefits cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. Also, I understand I may be charged a retrieval/processing fee and for copies of my medical records according to Texas Hospital Licensing law.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Printed Name Relationship to Patient

Identity of Requestor Verified via: Photo ID _____ Matching Signature _____ Other, Specify _____

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500, in the case of a first offense, and not mare than $5,000 in the case of each subsequent offense.