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AUTHORIZATION FOR THE USE OR RELEASE OF PROTECTED HEALTH INFORMATION

Name of Patient (Please Print) Date of Birth

Street Address City State Zip Phone Number Cell Number

Maiden name or other name used for records Practice Use: Medical Record #

I **hereby authorize:** (Please print) **To release to:** (Please Print)
Name: Name:

Address: Address:

Phone#: Fax: Phone#: Fax:

Please release the following: ____ Entire record **OR**:
____Problem List ___Genetic testing information ___Medication List ___Allergies ___Progress Notes ___H&P
____X-Ray/Imaging Reports-from (date) _____ to (date) _____
____Laboratory Results-from (date) _____ to (date) _____ Covering the period from:
____Other diagnostic reports_____ _____to_____
____Other (specify) _____

_____ **(Initial)** I understand that this authorization will include information relating to:
Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Syndrome (HIV) infection
Psychiatric care and Treatment for alcohol and/or drug abuse

If any, except as specifically stated here: _____
This information is to be disclosed for the purpose of:_____

The date, extent or condition upon which this authorization expires is__/__/__ not to exceed 24 months (except for research purposes, state "NONE" for expiration date). I understand that this authorization may be revoked at any time, except to the extent that action has been taken in reliance on this authorization.

I understand and agree to pay a reasonable fee to cover the cost of transfer of PHI. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I understand that Provider's records may contain information created by an entity other that **Texas Pediatric Specialties and Family Sleep Center** and therefore is not responsible for the information contained in such incorporated information (including the accuracy, completeness, relevance, legibility or lack thereof such incorporated records). I expressly request release of all records maintained by **Texas Pediatric Specialties and Family Sleep Center** concerning me, including incorporated records. I acknowledge that **Texas Pediatric Specialties and Family Sleep Center** has no and assumes no duty to me regarding the content of or omissions from such incorporated records.

I hereby release **Texas Pediatric Specialties and Family Sleep Center** and its personnel from all legal responsibility of liability that may arise from the act I have authorized above.
Texas Pediatric Specialties and Family Sleep Center is not responsible for completeness, legibility, or omissions used by the copying of any medical records from another institution.

_____ _____
Signature of patient or patient's representative Date

Printed name of patient's representative:_____
Relationship to patient: _____

Prohibition on redisclosure: This information, which has been disclosed to you from confidential records, is protected by federal law. Federal regulations prohibit you from making any further disclosure of this information except with the specific written authorization of the person to whom it pertains. A general authorization for the release of medical information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this shall be fined or imprisoned.