MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize you to release confidential health information about me or my child, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

Patient's Name: _____ Birth Date: _____

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.
Initial: _____ Date: _____

Limitations on the information you may release subject to this Release Form are as follows:

_____

Release my protected health information to the following person(s)/entity:

Richardson Pediatric Associates
1112 N. Floyd Road Ste. 7
Richardson, Texas 75080
(972) 952-0280
Fax (972) 852-6005

Previous Physician: _____

Phone #: _____ Fax #:_____

Street: _____

City: _____ State: _____ Zip: _____

The reasons or purposes for this release of information are as follows:

_____

Patient Signature [or parent, guardian or legal representative]:

_____

Date: _____

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.