

Pediatric & Adolescent Specialists of Rockwall
890 Rockwall Pkwy., Ste. 100, Rockwall, TX 75032
(214)771-3712 Fax (214)771-3796

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name _____ Date of Birth _____

Address _____ Social Security # _____ (optional)

I authorize Dr. Sonnen, MD,FAAP, Dr. Pascoe, MD, FAAFP, or Dr. Becker, MD to disclose medical information on the above named individual's health information to:

Physician Name: _____ Phone: _____

Physician Address: _____ State: _____ Zip: _____

By signing this form, the above patient consents to confidential information being released to the above listed physician, hospital, or organization for the purpose of: Patient Care / Request to send Records to Insurance

Please release the following:

Dates:

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Yes, I consent to the release of this information.

No, I do not consent to the release of this information.

I understand that the information released is for one of the specific purposes stated above. Any other use of this information without written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I also understand that this will not apply to information already released in response to this authorization. This revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions, I can contact the Office Manager at 214-771-3712.

Signature of Patient or Legal Representative

Date

Relationship to Patient (If Legal Representative)

Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Pediatric & Adolescent Specialists of Rockwall liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Signature of Patient or Legal Representative

Date

Relationship to Patient (If Legal Representative)

Witness

Date Request completed _____ # Pages copied _____ Reviewed only _____

Charges \$ _____ Cash _____ Check# _____ Initials _____

