LITTLE ELM - FRISCO CHILDREN'S CLINIC
12398 FM 423, Suite 600, Frisco, Texas, 75034 - (214) 494-4622

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

1. I AUTHORIZE: CHILD'S DOCTOR

_____
Name of sending person/organization

_____
Street Address

_____
City **State** **Zip Code**

( ) **( )**
Phone **Fax**

2. TO RELEASE TO:

Little Elm - Frisco Children's Clinic
12398 FM 423, Suite 600
Frisco, Texas 75034
Tel: (214) 494-4622
Fax: (214) 494-4609

3. PATIENT NAME:_____ DATE OF BIRTH: _____

4. INFORMATION TO BE RELEASED (Check all applicable):

☐ All Information ☐ All Progress Notes ☐ Lab Reports ☐ X-ray Reports
☐ Electrocardiogram (ECG) ☐ Allergy records ☐ Immunization Records ☐ Other: _____

SPECIAL AUTHORIZATION: Check applicable box(es) and sign immediately below.

By signing below, I am authorizing the office to release any and all information regarding:

☐ Alcohol ☐ Drugs ☐ Mental Health ☐ Sexually Transmitted Diseases
☐ HIV ☐ AIDS

Note: If this release pertains to alcohol, drug or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to who it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient's Signature:_____ Date: _____

5. RECORDS FROM THE TIME PERIOD: / / through / /

6. PURPOSE OF DISCLOSURE: (Check applicable purpose)

☐ Continued Medical Care ☐ Payment of Insurance Claim ☐ Legal ☐ Personal
☐ Workers' Compensation Claim ☐ Other: _____

7. I understand that this authorization shall be valid for one year. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

8. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

9. The requestor may be provided with a copy of this authorization

Patient/parent/guardian Signature: _____

Relationship to patient:	**Home Phone:**	**Work Phone:**	**Date:**

For office use only:

_____
MR# **Date** **Initials of Staff Member Sending**