DRIPPING SPRINGS PEDIATRICS

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PAYMENT OF $25.00 (OR MORE) PER CHILD IS REQUIRED PRIOR TO RELEASING FULL RECORD(S).
WE CAN SEND, FREE OF CHARGE, THE IMMUNIZATION RECORD, GROWTH CHART & MEDICAL SUMMARY LIST AS A COURTESY.

PLEASE LIST ALL PATIENTS YOU WISH TO HAVE RECORDS TRANSFERRED:

PATIENT NAME: ____________________ DATE OF BIRTH ____________

PATIENT NAME: ____________________ DATE OF BIRTH ____________

PATIENT NAME: ____________________ DATE OF BIRTH ____________

PATIENT NAME: ____________________ DATE OF BIRTH ____________

NEW OR CURRENT ADDRESS: ____________________ PHONE NUMBER: ____________

PLEASE SELECT WHERE YOU WISH TO HAVE THE RECORD(S) TRANSFERRED TO:

[ ] **I AUTHORIZE THE MEDICAL RECORDS TO BE RELEASED *TO* DRIPPING SPRINGS PEDIATRICS.**
PLEASE MAIL OR FAX RECORDS TO THE ADDRESS OR NUMBER LISTED BELOW.
(IF FAXING, PLEASE TRANSMIT EACH PATIENT'S DOCUMENTS SEPARATELY).

FROM: ____________________

ADDRESS: ____________________

CITY/STATE/ZIP: ____________________

PHONE: ____________ FAX: ____________

SEND TO: **DRIPPING SPRINGS PEDIATRICS**
331 SPORTSPLEX DRIVE, SUITE C
DRIPPING SPRINGS, TX 78620
PHONE: 512-894-3737
FAX: 512-894-3738

[ ] **I AUTHORIZE DRIPPING SPRINGS PEDIATRICS TO RELEASE MEDICAL RECORDS TO:**

NAME: ____________________

ADDRESS: ____________________ CITY/STATE/ZIP: ____________________

PHONE: ____________________ FAX: ____________________

INFORMATION TO BE DISCLOSED: MARK THE ITEMS BELOW THAT YOU WANT DISCLOSED.

[ ] **<u>ALL</u>** HEALTH INFORMATION (FEE OF $25.00 FOR 1st 20 PAGES & 0.50 PER ADD'L PAGE) ON OUTGOING RECORD(S) **<u>OR</u>**
[ ] **MEDICAL SUMMARY**/ IMMUNIZATION RECORD / GROWTH CHART (NO CHARGE)
<u>OR</u> SPECIFIC INFORMATION MARKED BELOW
[ ] PROGRESS NOTES FROM ____________ TO____________ [ ] ALL DATES

[ ] GROWTH CHARTS [ ] IMMUNIZATION RECORD [ ] HISTORY & PHYSICAL EXAM [ ] PROBLEM LIST

[ ] MEDICATION RECORD/LIST [ ] SPECIALISTS/CONSULT REPORTS [ ] BILLING INFORMATION

[ ] XRAY/DIAGNOSTIC REPORTS [ ] LABORATORY TEST REPORTS [ ] OTHER (SPECIFY) ____________________

YOUR INITIALS* ARE REQUIRED TO RELEASE THE FOLLOWING INFORMATION:
_______ MENTAL HEALTH RECORDS (EXCLUDING PSYCHOTHERAPY NOTES) _______ GENETIC INFORMATION (INCLUDING GENETIC TEST RESULTS

_______ DRUG, ALCHOHOL, OR SUBSTANCE ABUSE RECORDS _______ HIV / AIDS TEST RESULTS/TREATMENT

REASON FOR DISCLOSURE (CHOOSE ONLY ONE OPTION):
[ ] TRANSFER OF CARE [ ] TREATMENT/CONTINUED PATIENT CARE [ ] PERSONAL USE OR REVIEW [ ] BILLING OR CLAIMS

[ ] ATTORNEY/LEGAL [ ] INSURANCE [ ] SCHOOL [ ] OTHER ____________

SIGNATURE AUTHORIZATION: I HAVE READ THIS FORM AND AGREE TO THE USES AND DISCLOSURES OF THE PROTECTED HEALTH INFORMATION (PHI) ABOVE. THIS AUTHORIZATION WILL LAST FOR 1 YEAR FROM DATE OF SIGNATURE. I MAY REVOKE THIS AUTHORIZATION IN WRITING AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE UPON THIS AUTHORIZATION.

____________________ ____________________ ____________

SIGNATURE OF INDIVIDUAL OR LEGAL AUTHORIZED REPRESENTITIVE PRINTED NAME OF REPRESENTATIVE DATE

RELATIONSHIP TO INDIVIDUAL: [ ] PARENT OF MINOR [ ] LEGAL GUARDIAN [ ] SELF [ ] OTHER____________

*A MINOR INDIVIDUAL'S SIGNATURE IS REQUIRED FOR THE RELEASE OF CERTAIN TYPES OF INFORMATION, INCLUDING FOR EXAMPLE, INFORMATION RELATED TO CERTAIN TYPES OF REPRODUCTIVE CARE, SEXUALLY TRANSMITTED DISEASES, AND DRUG, ALCOHOL, OR SUBSTANCE ABUSE AND MENTAL TREATMENT.

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SIGNATURE OF MINOR DATE

IN ACCORDANCE WITH STATE LAW AND REGULATORY AGENCY REQUIREMENTS, THE HEALTH RECORD IS THE PROPERTY OF DRIPPING SPRINGS PEDIATRICS. HIPPA AND TEXAS HEALTH & SAFETY CODE ᵝ181.001 MUST OBTAIN A SIGNED AUTHORIZATION FROM THE INDIVIDUAL OR LEGALLY AUTHORIZED REPRESENTATIVE TO ELECTRONICALLY DISCLOSE THAT INDIVIDUAL'S PROTECTED HEALTH INFORMATION. AUTHORIZATION IS NOT REQUIRED FOR DISCLOSURE RELATED TO TREATMENT, PAYMENT, HEALTHCARE OPERATIONS, PERFORMING INSURANCE OR HEALTH MAINTENANCE ORGANIZTION FUNCTION, OR AS MAY BE OTHERWISE AUTHORIZED BY LAW.