

Authorization for Disclosure of Protected Health Information From Town Center Pediatrics to Third Parties

This completed form authorizes Town Center Pediatrics to disclose or release a patient's protected health information to third parties. A patient wishing to view his/her own information must complete a Patient Request for Access form. Please see the Instruction page (attached) before completing this form.

I. Patient's Name: _____ Birth Date: _____

Patient's Address: _____ Home Phone: _____

City, State, Zip: _____ Dates of Service: _____

II. Check the reports to be disclosed: (Please refer to copy fees on Instruction page.)

- | | |
|--|--|
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Billing Claims Forms |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Itemized Statement of Charges |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> All Information |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Other, specify: _____ |
| <input type="checkbox"/> Pathology Reports | |

Or, for mental health records (May require physician/psychologist approval):

- | | |
|--|--|
| <input type="checkbox"/> Psychiatric/Mental Health Records | <input type="checkbox"/> All information |
| <input type="checkbox"/> Neuropsychological Testing | <input type="checkbox"/> Other, specify: _____ |

III. Send the copies to: Name _____ Phone: _____

Mailing Address: _____

IV. For the purpose of: _____

V. I authorize Town Center Pediatrics to disclose the protected health information about myself (or the patient) as described above. I understand:

- This authorization expires 180 days from the date of my signature unless I specify otherwise.
Expiration: _____
- I may revoke this authorization at any time by notifying Town Center Pediatrics in writing. If I revoke the authorization I understand that it will have no affect on actions Town Center Pediatrics took in good faith before receiving the revocation.
- The information released may contain information related to AIDS or HIV infection; drug or alcohol abuse; mental or behavioral health or psychiatric care, except for psychotherapy notes.
- Town Center Pediatrics reserves the right to verify my identity/guardianship.
- I will be charged for the copies requested.
- I understand that Town Center Pediatrics may not condition treatment or payment on my completion of this form.

Signature: _____ Date _____

Printed Name: _____ Relationship to Patient: _____

Instructions for the Authorization for Disclosure of Protected Health Information Form

The patient's authorization is required in order for Town Center Pediatrics to disclose or release to third parties information from the patient's medical and/or billing records maintained by Town Center Pediatrics. All authorizations must be submitted in writing and include the information documented on the "Authorization for Disclosure for Protected Health Information" form. If the patient is a minor child, the legally authorized representative (e.g., parent) must authorize disclosure. (Patients wishing to view or obtain copies of their own information should fill out a different form, the Patient Request for Access form.)

Please follow the instructions below when filling out the Authorization form.
Numbers I-V refer to Sections I-V of the form.

I. Who is the patient?

Give the identifying information for the patient (or yourself, if you are the patient) so that we can locate the proper information. Fill in name, birth date, address, and dates of service for the treatment, test, or visit. If you do not know the exact dates of service, give a close range of dates.

II. Which information should be sent?

Place a check mark by the reports for which copies are needed. Do not mark "All Information" without considering the cost of the copies. (See the fees for copies below.)

III. Where should we send the information?

Give the name, address, and phone number of the person or organization that you want to receive the information.

IV. For what purpose is the information being released?

In other words, why does this person (or organization) need the patient's information? Give a brief reason.

V. Have you given us your permission?

We must have your authorization (permission) in writing to disclose your information. Please read the statements and sign to give your authorization. If you do not understand any of these statements you may call the Release of Information Office for more information.

Copy fees: You will be billed for copies according to state law. If fees are owed, a bill will be sent to you by mail. Once payment is received, Town Center Pediatrics will provide the copies as requested.

Town Center Pediatrics will provide you with a copy of the completed Authorization form at no charge upon your request.

For more information, contact Town Center Pediatrics at 3521 Town Center Blvd South, Suite A, Sugar Land, TX, 77479. 281-494-2255