Tots N Teens Pediatric Clinic

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

The fee for providing a copy of your medical records is $25 for the first 20 pages and $0.25 for each additional page.

Patient Name: _____ DOB: _____
Contact Number: _____
I authorize the following organization to release information as stated below from the patient health information record:

INFORMATION TO BE RELEASED FROM:	INFORMATION TO BE RELEASED TO:
Tots N Teens Clinics □ Forney □ Mesquite □ Plano or □ Organization/Person:	Tots N Teens Clinics □ Forney □ Mesquite □ Plano or □ Organization/Person:
Street Address: _____ City,State,Zip:	Street Address: _____ City, State, Zip:
Phone: Fax:	Phone: Fax:

INFORMATION TO BE RELEASED

□TNT Health Records □ Entire Record □ Billing Record □ Other (please specify) _____
Format for records (Please check only one box): □ Mail □ Fax □ Pick up

PURPOSE OF RELEASE

□ Legal □ Personal use □ Continuing Care □ Transfer to another provider □ School
□ Other: _____

AUTHORIZATION FOR GENERAL RELEASE OF INFORMATION

I understand that:

- Authorizing the disclosure of this healthcare information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can cancel this authorization at any time by written notification to Tots N Teens Clinics. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further releases or distribution by the recipient that may not be protected by confidentiality laws.

This authorization will expire 90 days from the date signed below unless another date or event is entered here: _____
(Note: If the disclosure is to another employer or financial institution, this authorization will expire 90 days from the date signed by you.)

SIGNATURE OF MINOR PATIENT REQUESTED FOR THE FOLLOWING RECORDS

A minor patient's signature is required to release the following information: 1: Information related to reproductive care such as birth control, pregnancy-related services and Sexually Transmitted Diseases, including HIV/AIDS (age 14 and older); 2: Substance abuse and mental health treatment (age 13 and older).

Signature of Minor Patient Date

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE

Signature of Patient or Legally Responsible Party Date

Relationship to patient

763 E. US HWY 80, Suite 210
Forney, TX 75126
(P) 469-290-4592
(F) 469-290-4593

1611 N. Belt Line Road, Suite B
Mesquite, TX 75149
(P) 972-285-0838
(F) 972-285-0848

3721 W. 15th Street, Suite 603
Plano, TX 75075
(P) 972-867-6880
(F) 972-596-0879