AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ _____
(Print Patient's Full Name) (Birth Date: mm/dd/yyyy)

_____ _____
(Street Address) (Social Security Number)

_____ _____
(City, State, Zip Code) (Home Phone Number)

I _____, do hereby authorize:
(Patient or Parent/Legal Guardian if Patient is a minor)

_____
(Name of Facility/Previous Doctor's Office)

_____
(Address of Facility/Previous Doctor's Office)

_____
(Phone/Fax Number of Facility/Previous Doctor's Office)

To release:
Progress notes___ Pathology Reports___ Other Doctor Notes ___ Lab Reports___
RadiologyReports___ HospitalNotes___ ECG/EEG/Cardio___ All Records ___
Other:_____

I Do / Do Not: Authorize release of information related to AIDS/HIV, or any other communicable diseases, psychiatric care, and/or psychological assessments, along with treatment for alcohol and/or drug abuse.

Information Should Be Released To:

JOY & CROWN PEDIATRIC SPECIALISTS
7002 LEBANON ROAD, SUITE 103
FRISCO, TX 75034
P:469-213-7633 F:469-535-3664

Purpose of disclosure: Referral to Specialist ____ Insurance ____ Worker's Comp____
Legal Investigation____ Disability ____ Personal ____ Relocated____
Other (specify):_____

I hereby authorize disclosure of the Protected Health Information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification; however, this will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization. I understand that I may REVOKE this authorization at any time.

Reason for transferring_____

Please provide a current phone number in case we need to contact you: _____

_____ **Date: _____**
Signature of Patient if 18+ yrs old

_____ **Date: _____**
Signature of Parent/Legal Guardian if Patient is a minor