Northeast Texas Pediatrics, PLLC
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Authorization for Release of Records

Patient Name _____ **DOB** _____

Address _____ **Phone** _____

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

Please choose Option 1 or Option 2 and complete the appropriate box.

Option 1: Send from another physician to Northeast Texas Pediatrics, PLLC

Sending Physician, please release my child's health information to Northeast Texas Pediatrics.

Sending Physician Name: _____

Street: _____

City: _____ **State** _____ **Zip**_____

Phone: _____ **Fax** _____

Option 2: Send from Northeast Texas Pediatrics, PLLC to another physician.

Northeast Texas Pediatrics, please release my child's protected health information to the following doctor.

Receiving Physician Name: _____

Street: _____

City: _____ **State** _____ **Zip**_____

Phone: _____ **Fax** _____

Please release the following:

___ All Records (or check the following that apply)
___ Progress Notes
___ History/Physical Exam
___ Immunization Record
___ Diagnostic Reports (Lab/Xray/EKG)
___ Hospital Reports
___ Other (Specify) _____

The reasons or purposes for this release of information are as follows:

_____
_____
_____

I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. I also consent to the release of information related to behavioral or mental health services and treatment for alcohol and drug abuse.

_____ **Yes,** I consent to the release of this information. _____ **No,** I do not consent to the release of this information.

I understand that I may revoke this authorization at any time in writing by sending written notification to the practice, otherwise this authorization shall expire on the 180th day after it is signed.

_____ _____
Patient Signature [or parent, guardian or legal representative] **Date**

_____ _____
Relationship to Patient [If parent, guardian or legal representative] **Witness**