Authorization for Release of Medical Information

Physician/Facility Name

Address | City | State | Zip

Phone Number | Fax Number

I hereby authorize the above stated physician/facility to release the following information:

- ☐ **Complete Medical Record**
- ☐ **Other, please specify:** _____

TO:

Pediatric Associates of Wylie, P.A.
501 Woodbridge Parkway
Wylie, TX 75098
972-442-2300 Fax: 972-442-2180

HIV/AIDS: 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.
Initial:_____ **Date:**_____

Release records regarding:

Patient Name | DOB: MM/DD/YYYY

Address | City | State | Zip

Signature of parent / legal guardian | Date

Acknowledgement of Understanding

This Authorization will expire 90 days after the date identified above. I understand that I may revoke this authorization at any time in writing, and it will be effective on the date notified except to the extent action has already been taken. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations. I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care. I understand that the physician/facility you have requested records from has 15 days by law to send us the records.