

I hereby authorize **LAKE LEWISVILLE PEDIATRICS, LLP** to release the following information from the medical records of :

(patient name) (Birth Date)

INFORMATION MAY BE RELEASED ONLY TO THE FOLLOWING PARTY (S)

NAME:

ADDRESS:

TELEPHONE #:

Pursuant to the requirements of the Texas Medical Practice Act, please be advised that the purpose or reason for this release is as follows:

INFORMATION OR MEDICAL RECORDS TO BE RELEASED BY MEANS OF THIS AUTHORIZATION INCLUDE THE FOLLOWING:

(LIST DATES OF ADMISSION AND DISCHARGE OR TREATMENT)

<input type="checkbox"/> History & Physical	<input type="checkbox"/> Diagnostic Testing & Results
<input type="checkbox"/> Discharge Summary	<input checked="" type="checkbox"/> Other (Please List) <i>shot record</i>
<input type="checkbox"/> Operative Record & Pathology	

I authorize you to INCLUDE information pertaining to the diagnosis and/or treatment of HIV testing, AIDS, psychiatric illness, and alcohol and/or chemical abuse and dependency. PLEASE INITIAL SPACE PRIOR TO STATEMENT.

I understand that my records are confidential and cannot be disclosed without my written authorization, except otherwise and provided by law.

I also understand that records pertaining to the diagnosis and/or treatment of HIV testing, AIDS, psychiatric illnesses, and alcohol or chemical abuse and dependency will not be released unless I have given my specific consent to release this information as indicated above.

I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it.

I understand that a photocopy or facsimile of this authorization is valid as the original.

(Signature of Patient or Legal Guardian) (Date)

(Relationship to Patient)

ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT(S) IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSES OF THIS DISCLOSURE.