I hereby authorize _____(Name)
_____ (Address)
_____ (City, State)
_____ (Phone #)
_____ (Fax #)

to release the following information from the medical records of :

_____ December 31 _____
(patient name) (Birth Date)

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

LAKE LEWISVILLE PEDIATRICS, LLP
2141 EDMONDS LANE
LEWISVILLE, TX 75067
972-315-8500 Fax: 972-315-8512

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)

☐ History & Physical
☐ Discharge Summary
☐ Operative Record & Pathology
☐ Diagnostic Testing & Results
☐ Other (Please List) _____
☐ Immunization Records

_____ 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.

_____ December 31 _____
(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.