



4461 Coit Road, Suite 315  
Frisco, TX 75035  
Phone: 972-731-9900 Fax: 972-731-9907

## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name \_\_\_\_\_

Patient DOB \_\_\_\_\_

I hereby authorize (previous pediatrician) \_\_\_\_\_

(Phone Number) \_\_\_\_\_ (Fax Number) \_\_\_\_\_

to release the following information to Collin County Pediatrics:

- CONTINUED CARE
- COMPLETE MEDICAL FILE
- Other (please specify) \_\_\_\_\_
- Other (please specify) \_\_\_\_\_

I understand that I may revoke this authorization at any time by notifying Collin County Pediatrics in writing, except to the extent that action has been taken in reliance on it. Unless earlier revoked, this authorization expires automatically 180 days after the day signed or 180 days after the last Collin County Pediatrics visit or after all insurance has been paid whichever occurs last.

**RELEASE FROM LIABILITY:** I release and agree to hold harmless Collin County Pediatrics and its agents, representatives, and employees from any liability associated with the release of confidential patient information in accord with this authorization.

**TO THE RECEIVING PARTY OF THIS INFORMATION:** This information has been disclosed to you for the sole purpose(s) stated in this authorization. Any other use of this information without express written consent of the patient is prohibited. The records may be protected by federal regulation. (42 C.F.R. Part 2)

I certify that this form has been fully explained to me, that I have read it or had it read to me, and that I understand the contents and will present identification upon pick up.

\_\_\_\_\_  
Parent/Guardian/Family Member Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient