

MCKINNEY PEDIATRIC'S AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION (PHI)

____ I hereby authorize the PHI of Patient's Full Name (Please Print): _____ Date of Birth _____ to be released to:

McKinney Pediatrics 4510 Medical Center Drive, Ste 207, McKinney Texas 75069 Fax: 972-548-0425 Phone: 972-548-0758

____ I hereby request McKinney Pediatrics disclose the PHI of Patient's Full Name: _____ DOB _____

_____ send PHI (medical records) to the address below: Name: _____ Phone #: _____ Fax# _____ Address: _____	_____ request the PHI (medical records) from the address below: Name: _____ Phone #: _____ Fax# _____ Address: _____
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I understand that McKinney Pediatrics will send the ___ PHI Record Summary and/or ___ Immunization Record. I also understand that I must request for the complete PHI to be sent. If the complete PHI is not requested, I leave it to the discretion of McKinney Pediatrics to send additional PHI for continuity of care. ___ I am requesting the complete PHI record to be sent. Other specify _____

The information is sent for the purpose of ___ Transfer to another Physician ___ Specialist ___ School/Day Care Requirement ___ Legality Purposes ___ Disability Benefits ___ Personal File ___ Other (Specify): _____

I understand that the information in my health record may include information relating to sexually transmitted disease(s), acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about 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 also understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient or authorized representative is prohibited. I understand that I may inspect or copy the protected health information to be used or disclosed as provided in CFR 164.524. I understand that I may revoke this authorization and must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal and state confidentiality rules. If I have any questions about disclosure of my health information, I can contact the Privacy Officer at McKinney Pediatrics.

Copying Fees for Medical Records: I understand the fee that will be charged for all record release will be twenty five dollars (\$25.00) for the first twenty (20) pages, and fifteen cents (\$0.15) per page thereafter. In addition, a reasonable fee to include actual costs for mailing, shipping or delivery. For an execution of an affidavit \$15.00 additional will be charged. The exception to this fee will be "transferred to another physician". By law records will be copied and MAILED 15 days from release date providing we have the appropriate permissions to release information and fees. If records are requested sooner than 15 days, you will be charged accordingly.

_____ Signature of Patient or Legal Representative	_____ Date
_____ Relationship to Patient (If Legal Representative)	_____ Phone
_____ Relationship to Patient (If Legal Representative)	_____ Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold McKinney Pediatrics, PA liable for any misinterpretation of the information in my medical record as a result of not consulting my physician or advanced nurse practitioner for the correct interpretation.

_____ Signature of Patient or Legal Representative	_____ Date
_____ Relationship to Patient (If Legal Representative)	_____ Witness

*So that we may continue to improve, when transferring to another practice, please let us know why. This will not affect the release of your records.
 ___ Moving ___ Provision of Care ___ Triage Service ___ Parking ___ Waiting Room ___ Billing ___ Other _____

Date request completed ___ # of pages copied ___ Reviewed only ___ Charges \$ ___ Payment type ___ Cash ___ Check # ___ Credit Card ___ Initials ___