TPG
Texoma Physicians Group
Pediatric and Adolescent Medicine

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Anna TX, 75409
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Sherman, TX 75090
Phone: 903-202-2900
Fax: 903-202-2901

Medical Records/Information Release TO Outside Entity

Please release all information from the record of:

_____ _____/_____/_____ _____-_____-_____
Patient Name – PRINT **Date of Birth** **Social Security Number**

_____ _____
Date(s) of Treatment – <ALL DATES> **Phone Number**

I hereby authorize: **Texoma Physicians Group, PLLC – Pediatric and Adolescent Medicine**

to release information to: _____
Name of Entity/Organization/Individual/Self

Address: _____
Street

_____
City **State** **ZIP**

_____ _____
PHONE **FAX**

Information to be released:

***Entire Chart/Record**
***Vaccination Record**
***Clinic Progress Notes**
***Emergency Notes**
***Laboratory Reports**
***Radiology Reports**
***Face Sheet**
***Other: _____**

Reason for patient information request:_____
-- If necessary. (examples: continuation/transfer of care, legal purposes, personal use, school…)

I understand that my records are confidential and cannot be disclosed without my direct written authorization, except when otherwise permitted by law. I understand the specific information to be disclosed may include, but is not limited to, history of drug and alcohol abuse, mental health treatment or information concerning communicable disease such as Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and laboratory results, treatment progress or any other such related information.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it. This authorization will expire 365 days from the date of my signature or as otherwise specified by date, event or condition as follows: _____.

I further authorize that a photocopy or facsimile of this authorization is acceptable as an original.

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in circumstances such as for participation in research programs or authorization of the release of testing results for the pre-employment purposes. Also, I understand I may be charged a retrieval processing fee for obtaining copies of my medical records according to Texas Law.

_____ _____ ____/____/_____
PRINT – Patient/Parent/Guardian/Legal Representative **Relationship to patient** **Date**

_____
SIGNATURE – Patient/Parent/Guardian/Legal Representative

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical records or other information held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500, in the case of a first offense and not more than $5000 in the case of each subsequent offense.