Morning Star Pediatrics

Authorization for Release of Medical Information

Please request medical information FROM:

_____

Name of Physician

_____

Street Address City, State Zip Code

_____

Phone Number Fax Number

I hereby authorize the above stated person/facility to release medical records TO:

Morning Star Pediatrics
940 Ridgeview Dr., Suite 130
Allen, TX 75013
Phone: 214-383-0434
Fax: 214-383-3178

- ☐ All Medical Records (Immunization record, Lab Reports, Radiology Reports)
- ☐ Medical Records within 90 days from last visit
- ☐ Lab and Radiology Reports
- ☐ New Born Screen
- ☐ Discharge Summary
- ☐ Immunization Record

Records to be released (check all that apply):

I understand that my medical records may include information regarding testing, diagnosis, and treatment of mental health, drug, alcohol, acquired immune deficiency syndrome (AIDS), hepatitis B, venereal disease, and other communicable disease. I understand that such information is confidential and is protected by federal law. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the discloser or use of my health information for purposes other than for treatment, payment, and healthcare operations. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPAA law.

I understand that my medical record may contain reports, tests 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 that has been written in the record.

I will not hold Morning Star Pediatrics liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation. I have read the above forgoing authorization for release of information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

I understand that I may revoke this authorization in writing at any time to the extent that Morning Star Pediatrics has already resided on this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. I further 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 is prohibited. This consent will expire 90 days after the date of signature.

Release Records Regarding:

_____

Signature of Parent/Legal Guardian Printed Name Date

_____

Patient #1 Name Patient DOB Phone Number

_____

Patient #2 Name Patient DOB

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