Authorization for Release of Medical Information

______________________________________ ________________
Patient Name Date of Birth

______________________________________ ________________
City, ST, Zip Phone Number

Date of Records Request: ________________

I, the undersigned, authorize/request the below named medical office/doctor to release my medical records.

____
Name of Physician/Office/Clinic/Hospital

______________________________________ ________________
Address Office Phone Number

______________________________________ ________________
City, ST, Zip Office Fax Number

Please release my medical records to the following:

Audrey Johnson, MD **Linh Ho, MD**

Cheryl Eley, MD **Beth Lessner, MD**

Children's Choice Pediatrics
6587 Virginia Parkway
McKinney, TX 75061
(972) 548-8382 Fax (972) 547-9951

My request for this particular release of medical records includes the following: (please initial appropriate line below**)**

____ All healthcare information, including information relating to HIV/AIDS, STD's, Psychiatric Disorders or Drug/Alcohol Abuse.

____ All healthcare information excluding information relating to HIV/AIDS, STD's, Psychiatric Disorders or Drug/Alcohol Abuse

The facility and its doctors are hereby released and discharged from any liability, and the undersigned will hold the facility and its doctors harmless for complying with this authorization.

______________________________________ ________________
Patient or Authorized Representative Signature Date

NOTICE TO PERSON OR AGENCY RECEIVING THIS INFORMATION: *This information has been disclosed to you from records whose confidentiality is protected. Statutes and regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.*