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:

Cheryl Eley, MD Kofoworola Kuboye, MD
Stacie Hunsaker, CPNP

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.*