**Willow Bend Pediatrics**
Michael J. Frank, M.D., F.A.A.P.
Susan J. Sickler, M.D., F.A.A.P.
Shobha Michaels, M.D., F.A.A.P.
Janet S. Le, M.D., F.A.A.P.

# Authorization for Disclosure of Confidential Information

I, _____ , hereby authorize the release of information from the medical record of :

Patient Name: _____ Date of Birth: _____

Home Address: _____ Phone Number: _____

I authorize :

Willow Bend Pediatrics
5940 Communications Parkway Plano, TX 75007
Phone Number: 972-403-9355 Fax Number: 972-403-1287

To : ☐Release medical information to ☐Receive information from (pick one)

Person/Office: _____

Phone Number: _____ Fax Number: _____

Address: _____

Email:

This information is necessary for the following purpose:

☐Moving to a New Area ☐Change of Insurance Plan
☐Patient outgrown pediatric age ☐Continuation of Care
☐Other (please explain) _____

Check information to be released:

☐Complete medical record – There may be a $25 charge for the first 20 pages, and each 50¢ per additional page for attorneys and insurance companies requesting records. This fee is in compliance with Texas State Board of Medical Examiners rules regarding fees for medical records.

☐Immunization ☐Lab Reports/X-ray ☐Progress Notes
☐Problem List ☐Other (please specify) _____

This authorization covers patient care given on dates of: _____

By signing this **I understand that:** I may revoke this consent in writing at any time except to the extent action has already been taken. This consent will expire 180 days after the date of my signature unless otherwise specified. I understand that there is a fee for copy services rendered and payment of the fee is due prior to my records release. I understand that this information may include HIV/AIDS, Mental Health & Chemical Dependency diagnosis, treatment, & test results. I understand that the information released is for the specific purpose stated above. I understand that my medical records may contain reports 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 Willow Bend 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 understand that within ***fifteen (15) business days*** of receipt of payment, my records will be available.

Signature : _____ Date: _____

Relationship to Patient: _____