# Medical Records Release Form

I authorize _____ (individual or entity, hereinafter known as the "Organization") to release confidential health information by distributing a copy of medical records, or a summary or narrative of the protected health information to Angel Pediatrics, P.A.

**Patient Name: _____ Date of Birth: _____**
(Last Name, First Name, MI)

**Please release the following health information:**
**(If you would like to transfer the whole record, please check "all medical chart & records")**

☐Medical Chart ☐Immunization Record only ☐ All Medical Chart & Records ☐Other (describe)

_____

**Limit the release of information subject to this Release Form as follows:**

☐None ☐One Time Use Only ☐Limit As Indicated

_____

**The reason(s) for this release of information:**

☐Moving Out of Area ☐Transferring Care Locally ☐Other (describe)

_____

**This authorization shall be in force and effective until the following event and/or date: _____**
**Disclosures**

I understand that additional information about this Medical Release is available from the Organization and that I may obtain a copy of that information from them.

I understand that information disclosed because of this authorization may be divulged by the recipient to others and as such may no longer be protected by federal medical privacy regulations.

I understand that the Organization, and the recipient of the information, will not condition my treatment and payment on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the person listed below. I understand that a revocation is not effective to the extent that the Organization has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

**Name of entity or person (the "Organization") who will release records to us:**

**Name: _____**

**Company: _____**

**Street: _____**

**City: _____State:_____ Zip:_____**

**FAX: _____ Phone: _____**

**Release the protected health information to:**

**Angela Asom M.D.**
**Angel Pediatrics P.A.**
**717 S Greenville Ave Ste 104**
**Allen, TX 75002**
**Phone: (972) 396-1900 FAX: (972) 396-1901**

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Relationship or Authority of Personal Representative