



RELEASE OF MEDICAL INFORMATION FORM

(From Acute Kids to a specified provider or parent)

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

I hereby authorize Acute Kids Urgent Care to disclose copies of the medical record information and/or protected health information of the patient listed above to:

Dr. _____ at _____
(address or fax)

OR to parent(s) _____
(names of parents or guardians)

Purpose: Further Treatment and Evaluation Treatment Date(s): _____

Expiration: This authorization shall expire on the 180th day after it is signed, unless as provided otherwise upon the expiration date.

I understand that I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any action taken prior to the health care facility receiving the revocation. Further details may be found in the Notice of Privacy Practices for Acute Kids Urgent Care.

If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.

Copy fees / charges will comply with the Texas Health and Safety Code, Chapter 241 and all other laws and regulations applicable to release of information.

I understand that treatment and payment are not a condition of signing this authorization. Upon request, I may receive a copy of this form after I have signed it.

I have read the above and authorize the disclosure of the protected health information as stated.

Patient / Parent / Guardian Signature: _____ Date: _____

Please FAX form to:

Frisco 214-618-3921	Plano 972-300-4201	McKinney 972-727-3801	Flower Mound 469-549-0302	Allen 972-359-6902	Admin Office 214-705-1095
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If you have any questions or need additional information please call:

Frisco 214-618-3920	Plano 972-300-4200	McKinney 972-727-3800	Flower Mound 469-549-0300	Allen 972-359-6900	Admin Office 214-705-1155
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