

# CHILDREN'S MEDICAL CLINICS

Of East Texas  
1011 W. Grove  
Kaufman, Texas 75142

Name of Patient \_\_\_\_\_ Date(s) of Service \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

I, the undersigned authorize the release of or request access to the information specified below from the medical record(s) of the above-named patient.

**PATIENT INFORMATION IS NEEDED FOR:**

Continuing Medical Care       Legal Purposes       School       Social Security/  
 Insurance       Personal Use       Other       Disability

**INFORMATION TO BE RELEASE OR ACCESSED:**

History & Physical       Consultation Report       Emergency Room Record  
 Operative Reports       Discharge/Death Summary       Face Sheet  
 Lab/Pathology Reports       X-ray Reports/Images       Vaccine Record

The above information may be released to (specify name or title of individual or the name of the organization to which records are to be released and the appropriate address):

\_\_\_\_\_  
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.)      Phone Number

\_\_\_\_\_  
Address (Street, City, State, Zip Code)

Information to be released from: \_\_\_\_\_  
(Doctor, Hospital, Attorney, Insurance Company, etc.)      Phone Number

\_\_\_\_\_  
Address (Street, City, State, Zip Code)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficient Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged a retrieval/processing fee and for copies of my medical records.

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition as follows:

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Patient or Legally Authorized Representative

\_\_\_\_\_  
Printed Name of Patient or Legally authorized Representative

\_\_\_\_\_  
Relationship to Patient

