



Authorization to Release or Disclose Protected Health Information

Patient's Name: _____ Date of Birth: ____/____/____ Date of Request: _____

Address: _____ Day Time Ph: (____) _____

(Street, city, state, zip code)

Please list where you would like Teddy Bear Pediatrics to request records FROM:

Facility Name/Office:	Fax Number
Address:	Phone Number
City State Zip	
Dates of Service	Reason for Request

The following information is to be sent to TEDDY BEAR Pediatrics: (Please check one box for each item if not requesting complete record.)

- Complete Record
 Well Visits
 Growth Chart
 Immunization Record
 Drug Allergy History
 Well Visits
 Problem List
 ADHD History
 Medication List

If you are wishing to have your records sent to TEDDY BEAR Pediatrics, send by

- **fax to: (877) 569-2885.**

- **Mail to:**

Teddy Bear Pediatrics & Sleep Medicine.
14300 Ronald Regan Blvd, Unit 405
Cedar Park, TX 78641

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing, and I understand the revocation will not apply to information already released based on this authorization.

Other Rights: a) I understand that authorizing the disclosure of this health information is voluntary and that I may refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I do not specify an expiration date, event or condition, this authorization will expire in six months from date signed.

By signing this form, I understand and accept full responsibility for the medical records I am requesting. I relinquish Teddy Bear Pediatrics & Sleep Medicine of any and all accountabilities concerning these medical records.

Signature of patient or legal representative

Date

If signed by legal representative, relationship to patient