Amarillo Pediatric Clinic PLLC

1901 Medipark Drive, Suite 65
Amarillo, TX 79106
Phone: (806) 468-4333
Fax: (806) 468-4334
www.apcamarillo.com

Erica Leathers, FNP-C * Alecia Litchfield, FNP-C * Julie Reel, FNP-C * Paula Saunders, FNP-C * Hayley Gibson, FNP-C

Authorization for Release of Information

Patient's Name:_____ **Date of Birth:**_____

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

I authorize and request that a copy of my medical records be released as follows:

Information to be released to:	Information to be released from:
Amarillo Pediatric Clinic, PLLC	_____
Name of Facility or Physician	Name of Facility or Physician
1901 Medipark Drive, Suite #65	_____
Address	Address
Amarillo, TX 79106	_____
City, State, Zip Code	City, State, Zip Code

PLEASE FAX OR MAIL REQUESTED INFORMATION

INFORMATION TO BE RELEASED:

	Dates:
Complete Record	_____
History/Physical Exam	_____
Immunizations	_____
Progress Notes	_____
Lab Reports	_____
X-Ray/Imaging Reports	_____
Other:_____	_____

_____

I specifically authorize the release of information relating to:

___Substance abuse (including alcohol/drug abuse)

___Mental health (including psychotherapy notes)

___HIV related information (AIDS related testing)

_____

Signature of Patient or Legal Guardian Date

PURPOSE OF DISCLOSURE:

___Legal ___Changing Physician ___Consultation/Second Opinion ___Continuing Care ___School
___Insurance ___Workers Compensation ___Other (please specify)_____

1. I understand that this authorization will expire 60 days after I have signed the form.

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.

3. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.

4. By releasing this information I understand: by authorizing this release of information, my health cae and payment for my health care will not be affected and I will get a copy of this form after I sign it. I also understand that I may see a copy of the information described in this form if I ask for it.

_____/_____/_____

Signature of Patient/Parent/Legal Guardian/Attorney Ad Litem Printed Name Date