STEPPING STONES
Pediatric and Adolescent Medicine

AUTHORIZATION TO RELEASE PROTECTED MEDICAL INFORMATION TO STEPPING STONES PEDIATRIC AND ADOLESCENT MEDICINE

NAME: _____ **D.O.B.**_____ **AGE:** _____
LAST FIRST M.I.

I, _____, hereby authorize
(Name of patient or legal representative)

_____
(Name of person/entity who should release records)

_____
(Address, phone, and fax number of person who should release records)

to release the following information by mail, fax, electronically or orally

TO:
Stepping Stones Pediatric and Adolescent Medicine
220 S. Denton Tap Road, Suite 201
Coppell, TX 75019
Phone: 972-393-8181 Fax: 972-393-5151

Reason for release of information: _____

SPECIFIC INFORMATION TO BE RELEASED:

____ Entire Medical Record, including patient histories, growth charts, vaccine records, office notes, test results, radiology studies, films, referrals, consults, and records sent to you by other health care providers.
____ History and Physical Examination
____ AIDS and HIV Related Information
____ Mental Health and/or Alcohol and Drug Abuse Treatment
____ Record of visit for a specific date(s). Specific dates include or are limited to: _____
____ Other (must be specific): _____

This authorization is given freely with the understanding that:

1. Any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as the original.
3. I may revoke this authorization at any time in writing, except where information has already been released.
4. Stepping Stones Pediatric and Adolescent Medicine, its employees, officers, and physicians are hereby released from any legal responsibility or liability for receipt of the above information to the extent indicated and authorized herein.
5. Information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient and may no longer be protected by this rule.
6. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization.

_____ _____
Patient/Legal Representative Signature Date

_____ _____
Relationship to Patient Expiration Date of Authorization