Midland Pediatric Associates
4214 Mamies Cr
Midland, TX 79707
Phone: 432-620-8687 Fax: 432-682-1831

MEDICAL RELEASE FORM

This authorizes you to provide a copy of medical records (as indicated by the checkmark(s) below) or otherwise release confidential information for:

Name: ____ D.O.B.: ________________________________

- ○ Complete Record
- ○ Records of care from _____________________ to _______________________
- ○ Records concerning the following conditions: _____________________________
- ● Other, please specify: **SHOT RECORD**
- ○ Confer with person(s) listed below orally about my medical information

Release of records **FROM** the following person(s)/clinic:

Name: MPA

Address: 4214 Mamies Cr
Midland, TX 79707

Phone: 432-620-8687

Fax: 432-682-1831

Release of records **TO** the following person(s)/clinic:

Name: ______________________________________

Address: ______________________________________
____

Phone: ______________________________________

Fax: ______________________________________

The Purpose for this release of information is as follows: ____

This authorization shall be in force and effective until: **6 months from the date below**, at which time the authorization to disclose this protected health information expires.

HIV/AIDS: I consent to the release of any positive or negative test results for HIV or AIDS infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.
INITIAL: _________________________ DATE: _________________________

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to MPA at 4214 Mamies Cr, Midland, TX 79707. I understand that a revocation is not effective to the extent that MPA has relied on the disclosure of the protected health information. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

MPA will not condition my treatment, payment, and enrollment in the health plan, or eligibility for benefits (if applicable) on whether I provide authorization for request disclosure.

____
Parent/ Legal Guardian

____
Date

____
Relationship to Patient

____
Witness

I understand that you will provide this information within 14 business days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set for by the Texas State Board of Medical Examiners.

DO NOT WRITE BELOW THIS LINE, FOR OFFICE USE ONLY

COMPLETED BY: ____ DATE: ______________________________________