



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: _____
- Confer with person(s) listed below orally about my medical information

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

Name: _____

Address: _____

Phone: _____

Fax: _____

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: _____