Treehouse Pediatrics

Authorization for Release / Request of Protected Health Information (PHI)

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Phone Number _____

Address: _____
Street City St Zip

_____ I authorize Treehouse Pediatrics to **release** information to:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # / Fax # (Include Area Code)

OR

_____ I authorize Treehouse Pediatrics to **obtain** information from:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # / Fax # (Include Area Code)

What information can be disclosed? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box:

☐ **All health information** ☐ Problem List ☐ Lab Reports ☐ Immunization Record
☐ Progress Notes ☐ Medication List ☐ Consultation Reports ☐ Billing Information
☐ History & Physical Exam ☐ X-Ray Reports ☐ Diagnostic Test Reports ☐ Other _____

Your initials are required to release the following information:

____Mental Health Records (excluding psychotherapy notes) ____Genetic Information (including Genetic Test Results)
____Drug, Alcohol, or Substance Abuse Records ____HIV/AIDS Test Results/Treatment

REASON FOR DISCLOSURE (Choose only one option):

☐ **Transfer** ☐ Treatment/Continued Patient Care ☐ Personal Use ☐ Billing or Claims
☐ Attorney/Legal ☐ Insurance ☐ School ☐ Other _____

Effective Time Period: This authorization is valid for **one time use only**, per the date signed below.

Signature Authorization: I have read this form and agree to the uses and disclosures of the information as described.

_____ _____
Signature of Individual or Legal Authorized Representative Date

Relationship to individual: ☐ Parent of Minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

_____ _____
Signature of Minor Date

In accordance with state law and regulatory agency requirements, the health record is the property of Treehouse Pediatrics. HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing an insurance or health maintenance organization function, or as may be otherwise authorized by law.

Prepayment Charge: There is a prepayment charge of $15 per record or a family limit of $25 for 2 or more records to copy and mail out transfer requests, in accordance with Texas Health and Safety Code §241.154.

******Please mail charts that are over 25 pages in length. Do not fax them. Thank you.******

15930 South Great Oaks Drive, Bldg B · Round Rock, TX 78681· 512.255.8868 · 512.255.8869 (fax) · www.treehousepedi.com