

**TEXAS CHILD NEUROLOGY, PLLC**  
**1708 COIT RD., SUITE 150**  
**PLANO, TEXAS 75075**  
**972-769-9000 ofc. 972-769-0035 fax**

**AUTHORIZATION FOR RELEASE OF INFORMATION**

**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

I certify that I am the Parent and / or Legal Guardian of the above named patient, and hereby request for:

**Physician/Clinic Name or Parent:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Send all Medical Records from:**

(Unless otherwise noted below)

**Texas Child Neurology, LLP**

1708 Coit Rd., Suite 150, Plano, Texas 75075

Information to be released:

- |   |  |
|---|--|
| <input type="checkbox"/> Discharge Summary  | <input type="checkbox"/> Operative Report                          |
| <input type="checkbox"/> History & Physical   | <input type="checkbox"/> Lab, X-rays, Pathology, EKG, EEG, CT Scan |
| <input type="checkbox"/> Progress Notes   | <input type="checkbox"/> Doctor's Orders                           |
| <input type="checkbox"/> Nurse's Notes  | <input type="checkbox"/> Psychiatric/Psychological                 |
| <input type="checkbox"/> Outpatient Clinic Visits <b><u>ALL DATES</u></b>   | <input type="checkbox"/> Other Hospital's: _____                   |
| <input type="checkbox"/> Entire Hospital Record<br>(Will include all information concerning testing, results and treatment for HIV (AIDS) communicable diseases, drugs/alcohol and mental health disease if any). |  |
| <input type="checkbox"/> Other (specify) _____  |  |

This information is released for the following purpose and that purpose only (any other use is forbidden).

**CONTINUITY OF CARE**

**TEXAS CHILD NEUROLOGY, LLP** is hereby released from legal responsibility or liability for the release of the records to the extent indicated and authorized herein. I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on (e.g., probation, paroling, etc.) and that in any event this authorization expires automatically as described below.

This authorization will expire **ONE YEAR** from the date of my signature or as otherwise specified by date, event or condition as follows.

\_\_\_\_\_  
Signature of Parent / Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**PROHIBITION OF REDISCLOSURE:** This information has been disclosed to you from records whose confidentiality is protected by both state and federal law. Federal regulation (42 CFR, Part 2) prohibits you from making any further disclosure of this information except with the specific written consent of patient. A general authorization for the release of information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than \$500.00 in the case of a first offense, and not more than \$5,000.00 in the case of each subsequent offense.