Coppell Pediatric Associates, P.A.
1705 E. Belt Line Rd., Coppell, TX 75019
Phone: 972-393-8687 Fax: 972-393-4975
www.coppellpedi.com
Tammi L. Schlichtemeier, MD, FAAP

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I request that the health information regarding the patient's care and treatment be released as set forth on this form.

_____ _____/_____/_____
PATIENTÕS LAST NAME FIRST MIDDLE DATE OF BIRTH

THIS INFORMATION WILL BE RELEASED FROM:

COPPELL PEDIATRIC ASSOCIATES, P.A.
DR. TAMMI L. SCHLICHTEMEIER
1705 E. BELT LINE RD.
COPPELL, TX 75019

PERSON TO WHOM THIS INFORMATION WILL BE SENT:

_____
NAME **ADDRESS** **FAX**

SPECIFIC INFORMATION TO BE RELEASED:

Ĭ SCHOOL FORM Ĭ SPORTS FORM Ĭ CAMP FORM Ĭ DAYCARE/PRESCHOOL FORM
Ĭ VACCINE REQUEST Ĭ OTHER: _____

Authorization to Discuss Health Information

□ **By initialing here** _____ I authorize _____ to discuss my health information with **Dr. Tammi L. Schlichtemeier or her Associates**

One copy of immunizations and one daycare/sports/school form provided per year per child free of charge. Further immunization records or forms completed are $5.00 per copy form, to be paid at the time of pickup.

I understand that the information released is for the specific purpose as designated above. I understand that this consent expires in 120 days after the date of my signature.

I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and then would no longer be protected by federal privacy regulations.

I may revoke this authorization by notifying **COPPELL PEDIATRIC ASSOCIATES, PA** in writing of my desire to revoke. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of the above named patient on whether or not I sign the authorization.

_____ _____ Ĭ Parent Ĭ Foster Parent Ĭ Legal Guardian
Signature of **parent or guardian** for minor child Date

_____ _____ _____
Signature of **patient** if 18 years of age or older Date SSN or Date of Birth

********MAY TAKE UP TO 3 BUSINESS DAYS TO COMPLETE REQUEST*******

OFFICE USE ONLY

	Ĭ Pt hearing/vision results added	
Ĭ Parent signed form	Ĭ Vaccine record printed	Provider completed (date) ___/___/___
Ĭ Parent completed form	Ĭ To provider (date) ___/___/___	Fax/call parent (date) ___/___/___
Ĭ Pt ht & wt vitals added	Staff initials _____	Staff initials _____