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.

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

PREVIOUS MD OR HOSPITAL OR ENTITY TO RELEASE THIS INFORMATION:

_____
NAME ADDRESS FAX

THIS INFORMATION WILL BE SENT TO:

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

SPECIFIC INFORMATION TO BE RELEASED:

☐ **Entire Medical Record**, including patient histories, growth chart, vaccine records, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults and records sent to you by other health care providers.

Include: (Indicate by Initialing) _____ Alcohol/Drug Treatment _____ Mental Health Information _____HIV-Related Information

☐ Other: _____

Authorization to Discuss Health Information

☐ **By initialing here** _____ I authorize _____ to discuss my health information with
(Name of Previous MD)
Dr. Tammi L. Schlichtemeier or her Associates

Reason for release of information: ☐ TRANSFER OF MD ☐ OTHER _____

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

OFFICE USE ONLY:

Date of Fax#1 _____/_____ Fax#2 _____/_____ Fax#3 _____/_____
Initial Initial Initial
Date Records Received _____ Chart reviewed by _____