Coppell Pediatric Associates, P.A.

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www.coppellpedi.com
Tammi L. Schlichtemeier, MD, FAAP

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

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

_____ _____/_____/_____
PATIENT'S 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

PROVIDER TO WHOM THIS INFORMATION WILL BE SENT:

_____
NAME OF PHYSICIAN OR CLINIC **ADDRESS** **FAX**

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

If sent to parent $25 fee for first 100 pages plus $.50 per page thereafter. $15 for digital copy.
Fee to be paid at time of request. No charge if sent to new MD!

☐ Other: _____

Authorization to Discuss Health Information

☐ **By initialing here** _____ I authorize _____ to discuss my health information with
(Name)
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.

_____ _____ □ Parent □ Foster Parent □ 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

Is there a custody issue with this child? Yes_____ No_____ Initial _____

OFFICE USE ONLY

□ Parent signed
□ Log note w/date of request ___/___/___
□ Electronic Health box checked on Log Note
□ Records to CD by day 3 (date) ___/___/___ Staff initials ____
□ Mailed out records (date) ___/___/___ Staff initials ____