

Coppell Pediatric Associates, P.A.

1705 E. Belt Line Rd., Coppell, TX 75019 Phone: 972-393-8687 Fax: 972-393-4975

 $\frac{www.coppellpedi.com}{\text{Tammi L. Schlichtemeier, MD, FAAP}}$

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Leaguest that the health information regarding the nationt's care and treatment be released as set forth on this form.

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PATIENT'S LAST NAME	FIRST	MIDDLE	DATE	OF BIRTH
THIS INFORMATION WILL BE RELI	EASED FROM:			
PROVIDER TO WHOM THIS INFORM	DR. TAMMI L. S 1705 E. BI COPPEL	RIC ASSOCIATES, P.A. SCHLICHTEMEIER ELT LINE RD. L., TX 75019		
		_		
NAME OF PHYSICIAN OR CLINIC	ADDRI	ESS		FAX
SPECIFIC INFORMATION TO BE	RELEASED:			
Entire Medical Record, including pateradiology studies, films, referrals, consults and			s (except psychotherapy n	otes), test results,
Include: (Indicate by Initialing) Al If sent to parent \$25 fee	for first 100 pages pl	us \$.50 per page there	after. \$15 for digita	
	e paid at time of reque	est. No charge if sent	to new MID:	
Other:				
Authorization to Discuss Health Infor	mation			
By initialing here I authorize	e		to discuss my health	information with
Du Tammi I. Sahliahtamaian an	(Na	me)		
Dr. Tammi L. Schlichtemeier or	Her Associates			
Reason for release of information:	TRANSFER OF MD	□ OTHER		
I understand that the information consent expires in 120 days after the I understand that the information unwould no longer be protected by for I may revoke this authorization by However, I understand that any act affect those actions. I understand of the above named patient on when	he date of my signature ised or disclosed may be subsederal privacy regulations. notifying COPPELL PEDITION already taken in reliance that the medical provider to	Te. ject to re-disclosure by the postarric ASSOCIATES, Page on this authorization cannowhom this authorization is fi	erson or facility receiving in writing of my desire t be reversed, and my rev	g it and then to revoke. ocation will not
Signature of parent or guardian i	For minor child Date	□ Pares	nt	□ Legal Guardia
Signature of patient if 18 years of	age or older Date	SSN	or Date of Birth	
Is there a custody issue with this cl	hild? Yes No_	Initial		
OFFICE USE ONLY			-	
☐ Parent signed ☐ Log note w/date of request/ ☐ Electronic Health box checked of		s to CD by day 3 (date) _ out records (date)/_	//_ Staff initia _/ Staff initials	als