Trinity Pediatrics, PA

Héctor L. Hidalgo, MD, FAAP
6105 Windcom Ct. #100 Plano, TX 75093
Tel: 972-473-9063 Fax: 972-473-9059

AUTHORIZATION FOR DISCLUSURE OF PROTECTED HEALTH INFORMATION (MEDICAL INFORMATION RELEASE AUTHORIZATION)

I understand that this form must be completely filled out. By signing this authorization, I authorize Trinity Pediatrics, P.A. to disclose certain protected health information about:

______________________________ (Patient Name) ______________________________ (Date of Birth)

Primary Phone #:______________________________________

The purpose of this release is: (specialist, insurance, new doctor, personal, etc.) ______________________

________________Summary: **$10.00** (includes shot record, growth charts, visit history)

________________Entire Chart: **$25.00** for the first 20 pages and **$.50 per page** for every copy thereafter

Please send the above protected health information to:

Name: ____

Address: ____

City: __________________________ State: ____________ Zip: _____________

Fax: __________________________ Phone: ____________________________

I understand that this release will expire on: ______________________. If unspecified, this authorization will expire in 180 days from date signed.

I don't have to sign this authorization in order to receive treatment at Trinity Pediatrics, P.A. In fact, I have the right to refuse to sign this authorization. I understand that specific information to be disclosed may include history of drug or alcohol abuse, mental health treatment, HIV/AIDS or any other medical information. When the medical information is disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that this practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer, 6105 Windcom Ct. #100, Plano, Texas 75093-7887.

______________________________ Signature of Patient or Legal Guardian

______________________________ Relationship to Patient

________________ Date