Windhaven Adolescent & Sports Medicine
THE NEXT STEP

17051 Dallas Parkway, Suite 340
Addison, TX 75001

Phone 972 473 8336 Fax: 972 735 8709

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient(s) name: _____ D.O.B ___/___/_____

Home Phone: _____ Cell Phone: _____

I hereby authorize: _____ Phone #:_____

Address: _____

Fax: _____ to release medical information on the patient(s) named above.

To: _____

Address: _____

Phone: _____ Fax: _____

Purpose for release of records: _____

My authorization is confined to the information checked below:

____ Statement of charges/payments ____ Radiology results

____ Hospital records ____ History/exam/notes

____ Immunization records ____ Lab results

____ Growth charts ____ all of the above

____ Other: _____

This authorization is given freely with the understanding that:

1. Any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without prior written consent, except as otherwise provided by law.
2. A photocopy or a fax of this authorization is as valid as the original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is called for a 1 year period from the date it is signed, or sooner if noted below. The revocation must be in writing.
4. Windhaven Adolescent Medicine, it's employees, officers, physicians are hereby released from any legal responsibility or liability for disclosure for the above information to the extent indicated and authorized herein.
5. Treatment, payment enrollment or eligibility for benefits may not be conditioned upon obtaining this authorization.
6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ _____
Patient (or guardian if under 18 years old) Date, event or condition of expiration (if less than 1 year)

_____ _____
Patient (or guardian if under 18 years old) Date

_____ _____
Witness Date

Rule 165.2
The physician responding to a request for such information is entitled to receive a reasonable, cost based fee for providing the requested information. Reasonable fee shall be a charge of 25.00 for the first 25 pages, and $0.50 per page thereafter. If an affidavit is requested to certify the information is true and correct, a reasonable fee of $15.00 may be charged for executing the affidavit.