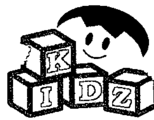

Dickerson Pediatrics, P.A.

of Sugar Land

Please note that each section of the form must be completed in its entirety. *Failure to specify (including dates) will delay the processing of your request.* Please allow DICKERSON PEDIATRICS 15 days for processing any release requests.

PATIENT INFORMATION:

Patient Name: ______________________________ Gender: Male Female
Last First Middle

Date of Birth: ______________________________ Phone: (____) ______________

Parent/Guardian/Requestor Completing Form:

____

☐ I AUTHORIZE DICKERSON PEDIATRICS P.A. to RELEASE information TO:

Name: ______________________________
Organization (if applicable): ______________________________
Street Address: ______________________________
City/State: ______________________________
Zip Code: ______________ Telephone: (__) ______________

☐ I AUTHORIZE DICKERSON PEDIATRICS P.A. to OBTAIN information FROM:

Name: ______________________________
Organization (if applicable): ______________________________
Street Address: ______________________________
City/State: ______________________________
Zip Code: ______________ Telephone: (__) ______________

METHOD OF RELEASE:

Information May Be:	**Records are to be released/obtained for the following purpose(s): *(Select all that apply)***
☐ **Mailed** ☐ **Faxed** (___)__________	☐ Medical Care
☐ Reviewed Only	☐ Attorney/Legal
☐ Discussed via Telephone	☐ Personal
☐ Picked Up By: ______________	☐ Insurance
☐ Verbal communication only; no records needed.	☐ Disability/SSI Other: ______________

INFORMATION AUTHORIZED TO BE RELEASED/OBTAINED:

☐**Dates of Treatment/Particular Illness/Admission Requested:** ______________	☐**Registration Sheets**
☐**Discharge Summary**	☐**Radiology Reports** ☐**Radiology Images** ☐**Lab Reports**
☐**History & Physical**	☐**Consultation Reports, Specify MD/Specialty:** ______________
☐**Operative Reports**	☐**Outpatient Clinic Notes, Specify Clinic(s):** ______________
☐**Emergency Department Record**	☐**Other Tests, please specify:** ______________
☐**IMMUNIZATIONS**	☐**Other:** ______________

This form authorizes DICKERSON PEDIATRICS P.A. to use and/or disclose protected health information in the manner described above and is voluntary. DICKERSON PEDIATRICS P.A. will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. The information used or disclosed as a result of this Authorization may be subject to re-disclosure by the person or entity receiving such information, and no longer protected by the federal privacy regulations. Unless otherwise revoked, this Authorization will expire six (6) months from the date it is signed. The signer may revoke this authorization at any time. Use of this information for any other than stated purpose is prohibited.

SIGNED BY: ______________________________ **DATE:** ______________

RELATIONSHIP TO PATIENT: ______________________________

FOR RECORDS BEING OBTAINED, PLEASE SEND RECORDS TO:

DICKERSON PEDIATRICS P.A.
4760 Sweetwater Blvd.
Suite 102
Sugar Land, TX 77479
Office: (281) 491-5439
FAX: (281) 240-0577