

**Pediatric Surgical Associates**  
**7000 W. Plano Parkway, Suite 400, Plano, TX 75093**  
**Phone: 214-483-9300      FAX: 214-483-9301**  
**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

Patient Name \_\_\_\_\_ PHONE # \_\_\_\_\_  
Date of Birth \_\_\_\_\_ For the purpose of: \_\_\_\_\_

I authorize **Pediatric Surgical Associates** to disclose the above named individual's health information.  
This information is to be released **TO:**

**ADDRESS:** \_\_\_\_\_

**OR FAX#:** \_\_\_\_\_

**PLEASE FAX COMPLETED FORM AND A COPY OF YOUR DRIVER'S LICENSE TO 214-483-9301**

Please release the following:

Entire Record                       X-Ray/Imaging Reports from \_\_\_\_\_ to \_\_\_\_\_  
 History/Physical Exam             Laboratory Results from \_\_\_\_\_ to \_\_\_\_\_  
 Other (Specify) \_\_\_\_\_

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).  
 **Yes**, I consent to release this information     **No**, I do not consent to release this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing the information. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date:

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.

I understand that I may inspect or copy the information to be used or disclosed.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I understand that if I have questions about disclosure of my health information, I may contact the **medical records department at Pediatric Surgical Associates at 214-483-9300.**

Signature of Patient or Legal Representative	Date
Relationship to Patient (If Legal Representative)	Witness

**COMPLETE ONLY IF INFORMATION IS RELEASED DIRECTLY TO PATIENT:**  
I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstandings of the information contained in these entries. I will not hold **Pediatric Surgical Associates** liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Signature of Patient or Legal Representative	Date
Relationship to Patient (If Legal Representative)	Witness