Authorization Release of Medical Records

I hereby authorize the release of medical record information of:

Patient Name: _____ Date of Birth:_____

Address/City/State/Zip:_____

Phone #:_____

From:

Physician Name:_____ Office Name: _____

Address:_____ City/State/Zip:_____

Phone #:_____ Fax #_____

TO: Sniffles & Giggles
201 Amanda Ln Ste 200
Waxahachie, Texas 75165
972-937-1300phone
972-937-1389 fax

I understand there may be a charge for my record, as permitted by Texas law.

Include this information (if applicable): __ alcohol/drug __Genetics __ HIV/AIDS __ Mental Health

Purpose of record; __ Continued Care __ Insurance __ Personal Use __ Attorney/Legal

Information to be released: _____Complete medical record _____ Items as indicated below

_____ Progress Notes	_____ Problem List	_____ Consultations
_____ Lab Reports	_____ X-ray Reports	_____ Immunizations
_____ Medication List	_____ H&P	_____ Mental Health Records

_____ Other specify:_____

In accordance with state law and regulatory agency requirements, the health record is the property of **Sniffles & Giggles, LLC**. By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed.

Prohibition on re-disclosure: This information is being disclosed from records whose confidentiality is protected by state and federal law. These laws prohibit any further re-disclosure without specific consent of the patient or legal guardian/representative. I may revoke my authorization at any time with written notice. This authorization will expire 180 days from date indicated below.

_____ _____

Parent, guardian or legal representative **Date**

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.