AUSTIN HEALTH PARTNERS

Cedar Park Pediatric & Family Medicine
Complete Medical Care for your Family

Authorization for Release / Request of Protected Health Information (PHI)

Prepayment Charge: There is a prepayment charge of $10 per child for electronic records to be faxed and $25 per child for records to be printed and picked up in office, in accordance with Texas Health and Safety Code §241.154. (Option B below)

Patient Information:_____
Name Date of Birth Phone Number

Address:_____
Street City State Zip Code

___I authorize Austin Health Partners and Cedar Park Pediatric & Family Medicine to **release (transfer out)** information to:

_____
Name of Provider or Facility/or Parent Name

_____
Address

_____
City, State, Zip Code

_____
Fax # (MUST be included along with Area Code)*
****Fax number must be included in order to process request****

OR

___ I authorize Austin Health Partners and Cedar Park Pediatric & Family Medicine to **obtain (transfer in)** information from:

_____
Name of Provider or Facility/or Parent Name

_____
Address

_____
City, State, Zip Code

_____
Fax # (MUST be included along with Area Code)*
****Fax number must be included in order to process request****

Please select the option that best suits your needs for transferring records out:

Option A (records sent electronically, $10 charge) Option B (records printed & picked up in office, $25 charge required)

REASON FOR DISCLOSURE (Choose only one option):
Treatment/Continued Patient Care Personal Use Attorney/Legal Insurance

Signature Authorization: I have read this form and agree to the uses and disclosures of the information as described.

_____ _____
Signature of Individual or Legal Authorized Representative Date

Relationship to individual: Parent of Minor Guardian Other

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

_____ _____
Signature of Minor Date

In accordance with state law and regulatory agency requirements, the health record is the property of Austin Health Partners. HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or legally authorized representative to electronically disclose that Individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing an insurance or health maintenance organization function, or as may be otherwise authorized by law.

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