Harlingen Pediatrics Associates

Medical Records Release Form
(Please circle release or request)

Patient Name: _____ DOB_____

By signing this form, I hereby authorize the release or request of medical records to the person(s) or entity below.

Name_____

Address_____

City_____ State_____ Zip_____

Phone_____ Fax_____

Please release or request the following:

_____Complete Medical Chart
_____Sick or Well visit
_____Immunization Record
_____Lab or x-ray results
_____Hospital Records
_____Other_____

HIV/AIDS: I consent to the release of any positive or negative test for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.

I, the undersigned, have read the above and authorized the staff of Harlingen Pediatrics Associates to disclose or request such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I understand that re-discloser of this information to a party other than the one designated above is forbidden without additional authorization on my part. This facility is released and discharged of any liability and the undersigned will hold the facility harmless, for complying with this "Authorization for Release of Medical Information." Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for (1) conducting research-related treatment, (2) obtaining information in connection with the eligibility for enrollment in a health plan, (3) determining an entity's obligation to pay a claim, or (4) creating health information to provide to a third party.

This authorization expires one year from the date signed below.

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

_____
Signature of parent/guardian (patient if over 18 years of age) Date

_____
Signature of witness

Stanley J. Fisch, M.D. • Dorila E. Mauney, M.D. • Maribelle Garza, M.D. • Roland J. Dominguez, M.D. Erwin D. Sanchez, M.D.
Francisco R. Padilla, M.D. • Denise Hilckman, PNP • Leticia L. Garcia, F.N.P. • Teresa Gallegos, LMSW
321 S. 21st Street / Harlingen, TX 78550 / 956-425-8761 / FAX 956-425-9207