Lone Star Physicians Group, P.A.

Authorization to Release Medical Information

I AUTHORIZE:	
From: Iresh Kumar, MD, FAAP	**To:**
	(Child's physician/Clinic)
PO Box 1480	**Address:**
Frisco, TX 75034	**City:** **State** **Zip**
Phone: 214-705-9696	**Phone:**
Fax: 214-705-9697	**Fax:**

Child's Name:	**Date of Birth: / /**

INFORMATION TO BE RELEASED: (Check all applicable)

☐ Complete Record	☐ All Progress Notes	☐ Laboratory Reports	☐ Radiology Reports
☐ Immunization Record	☐ Allergy Records	☐ Consultations	☐ Other:

RECORDS FROM THE TIME PERIOD: / / through / /

PURPOSE OF DISCLOSURE: (Check applicable purpose)

☐ Continued Medical Care	☐ Payment of Insurance Claim	☐ Legal
☐ Personal	☐ Workers' Compensation Claim	☐ Other:

♦I understand that this authorization shall be valid for one year from the date below. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

♦ I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

♦ The requestor may be provided with a copy of this authorization.

Parent/Guardian signature	**Date**
Name of Parent/Guardian (Print)	**Relationship to patient:**
	☐ **Parent** ☐ **Guardian** ☐ **Legal custodian**

SPECIAL AUTHORIZATION: Check applicable box(es) and sign immediately below.
By signing below, I am authorizing the office to release any and all information regarding:
☐ Alcohol ☐ Drugs ☐ Mental Health ☐ Sexually Transmitted Diseases
☐ HIV/AIDS

Note: If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Parent/Guardian Signature	**Date**

For office use only:

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MR# **Date** **Initials of Staff Member Sending**