First Step Pediatric Associates, P. A.
Ayman Arouse, MD

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND PHI

All areas of this form must be completed, signed & witnessed for this form to be valid

Disclosure of Personal Health Information (PHI), as required by applicable Federal & State Law, will be permitted only by following the HIPAA Privacy Practices that are set forth In the First Step Pediatrics Associates, P.A. Privacy Notice. A patient's privacy will be maintained in all Instances where use of PHI Is applicable. A copy of this Privacy Notice Is available effective April 14, 2003.

Request records from the following

Facility Name_____ Phone_____ Fax_____

Address_____ City_____ State_____ Zip_____

Patient Information

Name_____ DOB_____ Phone#_____

Address_____ City_____ State_____ Zip_____

I _____ Authorize the above listed person's, physician's, firm, or entity (or its agent representatives, or employees) to release for inspection and copying and all the Personal Health Information (PHI) listed below that pertain to my treatment, hospitalization, or care from the dates of: _____ to _____.

	Entire Record Inpatient/Outpatient		Lab Reports/Pathology Reports
	EMG/NCV		OP Reports
	Prior Physician Office Medical Rec's		Physical Therapy
	Radiology: X-Ray's/MRI/CT Scans		ER Records
	IME/DDE/FCE		Shot Record

Please mail medical records to the following:

First Step Pediatric Associates, P.A.
895 N Nolan River Rd. Ste 101
Cleburne, Tx 76033
Phone 817-641-8800 Fax 817-641-8803

***Please fax ONLY vaccine records to 817-641-8803 and mail all other record to address above, unless specified.**

*****Please continue to next page and print, sign, and date the medical release*****

Purpose for Requesting Release

Reason for request_____

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). It may also Include Information about behavioral or mental health services and treatment for alcohol and drug abuse.

The party requesting the records may be charged a $25.00 fee for the first twenty (20) pages plus $0.15 for each additional page and a reasonable fee for the actual mailing, shipping, or delivery of these records. The Texas Medical Board (TMB) rule also allows physicians to retain the records until payment Is received for the processing of release of medical records. This authorization will remain in effect for 180 days. The patient's authorization below confirms his/her agreement for this Disclosure of his/her PHI. Once a completed, signed authorization Is received in our office, please allow three (3) to five (5) business days for processing this request. A photocopy of this authorization will have the same effect and force of an original.

Right to Revoke and Refuse to Sign:

1. I understand that I may revoke this authorization at any time by notifying First Step Pediatric Associates, P.A. In writing, but If I do It will not have any effect of any actions they took before they received the revocation.
2. I understand that I do not have to Sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment, nor will It affect my eligibility for benefits.
3. I understand that refusal to sign will not permit you're treating physician(s) access to medical records that may be necessary for provision of optimal diagnosis and treatment of my current condition and may compromise my health.
4. I understand that, if my protected health Information Is disclosed to someone who Is not required to comply with the federal privacy protection regulations, then such Information may be re-disclosed and would no longer be provided.

My signature or that of my personal representative testifies that I/my personal representative have read, agree to and understand the content of this authorization for release of PHI.

Print Name_____ Relationship to Patient_____

Signature_____Date_____

COMPLETE ONLY IF INFORMATION IS TO BE 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 any misunderstanding of the Information contained in these entries. I will not hold First Step Pediatric Associates, P.A. or Its physician(s) provider's, or employee's liable for any misinterpretation of the Information In my medical records as a result of not consulting my physician for the correct Interpretation.

Print Name_____ Relationship to Patient_____

Signature_____ Date_____

Office Use Only

Witness Name_____

Signature_____

Date_____