TLC Pediatrics of Frisco
Seth D. Kaplan, M.D.
Heather Hummel, M.D.

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as the original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist.
4. Seth D. Kaplan, M.D., P.A., its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this Authorization.
6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

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Medical Records Release Form

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 below.

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

Limitations on the information you may release subject to this Release Form are as follows:

____

Release protected health information from the health records of:

Name: ____ **DOB:** _______________

Name: ____ **DOB:** _______________

Release protected health information from:
Name: ____

Address: ____

Tel # ____________________________________ **Fax #** ___________________________

Release my protected health information to:

TLC Pediatrics of Frisco
3550 Parkwood Blvd, Suite 701
Frisco, TX 75034
(214) 618-6272 fax (214) 618-6277

The reasons or purposes for this release of information are as follows:

____

Patient signature (or 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.