RAINBOW CHILDREN'S CLINIC

1900 Ballpark Way #106
Arlington, TX 76006
Tel: 817-704-7339 Fax: 682-276-6049

Authorization to Release Health Information

Patient Information:

Name of Patient _____ Date of Birth _____

Address _____

City, State, Zip _____ Phone _____

Name of Releasing Facility: ***(Previous Doctor)***	***Send Records to:*** ***(New Doctor)***
Name:	Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone:	Phone:
Fax:	Fax:

***** MEDICAL RECORDS THAT EXCEED 25 PAGES MUST BE RECEIVED BY MAIL ONLY.**
PLEASE DO NOT FAX
***** DISC FILES MUST BE IN TIF OR JPEG FORMAT ONLY**

INFORMATION TO BE RELEASED

☐ IMMUNIZATION RECORD ONLY ******* PLEASE FAX SHOT RECORD AS SOON AS POSSIBLE

☐ MEDICAL RECORDS – Date Range: _____ to _____ ☐ ALL RECORDS

☐ TEST RESULTS: TYPE OF TEST: _____ Date_____ ☐ ALL TESTS

☐ OTHER _____

This authorization will expire when I revoke this authorization in writing.

Patient Rights:

- I may refuse to sign this authorization and I have the right to revoke this authorization in writing at any time.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I understand released health record may contain information in reference to Hepatitis B or C testing, HIV testing and or other sensitive information, including mental health and substance abuse.
- I understand that if I wish to have copies made, then the facility may assess a fee for copying the records. I will be notified of the total amount due for copying and shipping the requested records. I agree that the facility will only send me the requested information once it has received payment in full for those costs. I may inspect or copy the protected health information to be disclosed as described in this document
- The personal health information contained in this fax is highly confidential. It is intended for the exclusive use of the addressee. It is to be used only to aid in providing specific healthcare services to the patient. Any other use is in violation of the Federal Law, Health Insurance Portability Accountability Act (HIPAA) and will be reported as such.

_____ Date _____
Signature of Person Making the Request

Print Name _____ Relationship to Patient_____