Protected Health Information Release Form

Patient Name:_____DOB:_____

Patient Name:_____DOB:_____

Patient Name:_____DOB:_____

Patient Name:_____DOB:_____

By signing this form, I hereby authorize:

Physician Name:_____

Phone Number: _____ Fax Number:_____

Address:_____

to release confidential health information about my children/child. By releasing a copy of my children/child medical records via fax/mail, or summary or narrative of his or her protected health information to the person(s) or entity listed below:

Susan Bacsik, DO

Phone: 469-300-5437 Fax: 469-619-8619

1107 W Jefferson Blvd  Dallas, TX, 75208

www.OakCliffPediatrics.com

I understand that you will provide this information within 15 days from my 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.

Printed name: _____ Date signed:_____

Signature: _____ Relationship to patient(s):_____