



Minor Emergency and Urgent Care for KIDS of ALL Ages!
RELEASE OF MEDICAL INFORMATION FORM

Patient Name: _____ DOB: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

I hereby authorize Acute Kids Urgent Care to disclose copies of the medical record information and/or protected health information of the patient listed above to:

Dr. _____ at _____
(address or fax)

OR to parent(s) _____
(names of parents or guardians)

Purpose: Further Treatment and Evaluation Treatment Date(s): _____

Expiration: This authorization shall expire on the 180th day after it is signed, unless as provided otherwise upon the expiration date.

- I understand that I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any action taken prior to the health care facility receiving the revocation. Further details may be found in the Notice of Privacy Practices for A-Cute Kids Urgent Care.
- If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
- Copy fees / charges will comply with the Texas Health and Safety Code, Chapter 241 and all other laws and regulations applicable to release of information.
- I understand that treatment and payment are not a condition of signing this authorization. Upon request, I may receive a copy of this form after I have signed it.
- I have read the above and authorize the disclosure of the protected health information as stated.

Patient / Parent / Guardian Signature: _____ Date: _____

PLEASE FAX FORM TO:

Frisco	Plano	McKinney	Flower Mound
214-618-3921	972-300-4201	972-727-3801	469-549-0302

If you have any questions or need additional information please call:

Frisco	Plano	McKinney	Flower Mound
214-618-3920	972-300-4200	972-727-3800	469-549-0300