AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of information from the medical records of:
Yo doy la autorization de relizar la information medica de:

Patient Name/ Nombre del Patiente _____ Date of Birth/ Fecha de Nacimiento _____

Address/Direccion _____ Phone Number/ Telefono _____

From / De:

Name of Previous Clinic/ Nombre De La Clinica Anterior _____

Address/ Direccion _____ Phone Number/Telefono _____

To be released to:

Sunrise Pediatrics & Adolescent Center
Dr. Dolores Ifezue
1201 19th Street
Plano, TX 75074
Ph. (972)-424-5437 Fax (972)-424-5438
PLEASE MAIL MEDICAL RECORDS
If more than 25 pages

Please release the following:

__All medical records
__Labs/x-rays/EKG report
__Summary sheet only
__Including information relating to HIV/AIDS, Psychiatric Disorder or Drug Abuse.
__Immunization records only (**URGENT FAX ASAP**)
__ OTHER_____

I understand that the information released is for the specific purpose designated above, and this consent expires in 365 days after the date of my signature. The facility and doctor are hereby released and discharge from any liability, and the undersigned will hold the facility and its doctors harmless for complying with this authorization.

Signature/Firma _____ Date/ Fecha _____

NOTICE TO AGENCY RECEIVING THIS INFORMATION: This information has been disclosed to you from a records whose confidentiality is protected, Statutes and regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.