

Attachment A
Patient Request for Access to Protected Health Information

I. Patient's Name: _____ Birth Date: _____
 Address: (City, State, Zip) _____ Home Phone: _____
 Dates of Service: _____ Date Information Needed: _____

II. Mail copies to (address) check if same as above. If different, please provide address: _____
 City, State, Zip: _____ Contact Number: _____

III. I authorize Texas Children's Pediatric Associates (TCPA) to disclose the protected health information about myself (or the patient) as described above. I understand:

- This authorization expires 180 days from the date of my signature unless I specify otherwise.
 Expiration: _____
- I may revoke this authorization at any time by notifying TCPA in writing. If I revoke the authorization, I understand that it will have no affect on actions TCPA took in good faith before receiving the revocation.
- The information released may contain information related to AIDS or HIV infection; drug or alcohol abuse; mental or behavioral health or psychiatric care, except for psychotherapy notes.
- If the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
- TCPA may not condition treatment or payment on my completion of this form.
- TCPA reserves the right to verify my identity/guardianship.
- I will be charged for the copies requested.

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____

IV. I want to obtain copies of the following reports (check):

Document Types	Fee		Fee
<input type="checkbox"/> Patient transfer summary Summary of chart for release to another physician	\$25.00	<input type="checkbox"/> Affidavit	\$15.00
<input type="checkbox"/> Immunization Record	\$ 5.00	<input type="checkbox"/> CPS Record Request	\$25.00
<input type="checkbox"/> Lab Report	\$ 5.00	<input type="checkbox"/> Worker's Compensation Request	\$25.00
<input type="checkbox"/> Growth Chart	\$ 5.00	<input type="checkbox"/> Retrieval Fee for record from storage	\$25.00
<input type="checkbox"/> Entire Paper Record	\$25.00		
<input type="checkbox"/> Electronic Record via CD	\$25.00		
<input type="checkbox"/> Other Please specify _____			

IV. Transferring Out of Practice. Please check reason:

- Moving out of city/state
- Child is switching to adult physician
- Practice does not accept insurance
- Dissatisfied with care