



1 CP Place PLLC
7709 San Jacinto Place, Ste. 203
Plano, TX 75024
P: 469-331-0030
F: 469-331-0031

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Fax Number: _____

I request and authorize 1 CP Place PLLC to transfer, release, or obtain healthcare information of the patient named above to/from:

Obtain From: _____ Release To: _____
Physician/Clinic: _____ Physician/Clinic: Dr. Janice Brunstrom-Hernandez/1 CP Place
Address: _____ Address: 7709 San Jacinto Place, Ste 203
Plano, Texas 75024
Phone: _____ Phone: 469 331-0030
Fax: _____ Fax: 469-331-0031

This request and authorization applies to:

- Physician Visit Notes (Neurologist Orthopedic Surgeon Neuro Surgeon PMNR Dev. Pediatrician Pediatrics Geneticist Other specialist)
Birth records (include NICU discharge & summary) Hospital discharge summary Operative Reports
Procedure Records (e.g. for Botox) Growth Charts (height, weight, head circumference)
PT/OT/ST Records Hip X-rays (actual images on CD/DVD and Report) Spine X-rays EEG Reports
MRI/MRA Imagery of brain & spine Genetics results Laboratory results Bone Density results
Immunization records Other test results
Healthcare information relating to the following treatment, condition, or dates:
Other (specify):

For the purpose of:

- Comprehensive Evaluation & Care Continuing Medical Care Insurance School Legal Purposes
Social Security/Disability Patient/Parent Request Military
Other (specify):

I acknowledge and understand this consent and have signed it voluntarily. I acknowledge and understand that I may revoke this authorization in writing at any time.

Patient/Parent Signature: _____ Date : _____

AUTHORIZATION EXPIRES NINETY DAYS AFTER DATE OF SIGNATURE OR ON _____