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.

Patient Signature: ______________________ Date : ____________

AUTHORIZATION EXPIRES NINETY DAYS AFTER DATE OF SIGNATURE OR ON ____________

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