

# Hometown Pediatrics

1595 Lake Front Circle  
The Woodlands, TX 77380

(281) 292-8980 (Office)

(281) 292-8070 (Fax)

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## AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Child's First & Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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Child's First & Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Child's First & Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

***I do hereby authorize  
my child's medical  
records from:***

***Name of Medical Practice, Physician, Clinic or Hospital***

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax \_\_\_\_\_

***...to be released to:***

**Hometown Pediatrics, P.A.**

**1595 Lake Front Circle**

**The Woodlands, TX 77380-3604**

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***...for the purpose of:***  *continuing or transfer of medical care*  *proof of immunization*  
 *insurance review or underwriting*  *legal matters*

Release information concerning the ***following dates:*** from \_\_\_\_\_ to \_\_\_\_\_, and to include:

***complete medical records*** in your possession to include illness(es) and/or treatments

***or***  medical records ***limited to the following specific types of information:***

***Also,*** I  **DO** or  **DO NOT** (check one & initial \_\_\_\_\_) consent to release of information relating to psychiatric or psychological testing or treatment, biofeedback training, alcohol and/or drug abuse diagnosis/treatment, or HIV (AIDS) testing

I, the parent/guardian, agree that ***a photocopy or facsimile (fax) of this authorization may be considered valid***, this authorization shall be ***valid for 120 days from the date of signature***, and that ***this authorization can be revoked in writing at any time prior to the expiration date.***

I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless Hometown Pediatrics, PA from all liability and damage resulting from the lawful release of my Protected Health Information.

Parent/Guardian Printed Name \_\_\_\_\_ Signature X \_\_\_\_\_

rev 10/10 Relationship to Patient (circle one) : ***self mother father guardian*** Date: \_\_\_\_\_