

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: _____

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

Name of Medical Practice, Physician, Clinic or Hospital

Address _____

City, State, Zip _____

Phone Number _____

...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 the above named medical practice, physician or facility from all liability and damage resulting from the lawful release of my Protected Health Information.

Parent/Guardian Signature: _____ **Date:** _____