

# Hometown Pediatrics

## PATIENT INFORMATION

(Please Print Clearly)

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: (circle) Male Female

Social Security #: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Father's Cell Phone #: \_\_\_\_\_ Mother's Cell Phone #: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Work #: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Work #: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

### Emergency Contact

(Other Than Listed Above)

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

### Insurance Information

*Insurance information is a necessary part of your child's record. We will strive to direct your care and your need for specialist consults, lab work and other tests according to your managed care guidelines. However, our office deals with many different plans and **it is the patient's responsibility to make sure that all facilities and specialists that we refer you to are on your health plan.** Please verify their participation **BEFORE** services are rendered to receive network benefits from your insurance company.*

| Primary Insurance                    | Secondary Insurance                  |
|--------------------------------------|--------------------------------------|
| Policy Holder: _____                 | Policy Holder: _____                 |
| DOB: _____ SS#: _____                | DOB: _____ SS#: _____                |
| Relationship to Patient: _____       | Relationship to Patient: _____       |
| Insurance Company: _____             | Insurance Company: _____             |
| Address: _____                       | Address: _____                       |
| Phone #: _____ Effective Date: _____ | Phone #: _____ Effective Date: _____ |
| ID #: _____ Group #: _____           | ID #: _____ Group #: _____           |

**\*\*Whom may we thank for referring you to Hometown Pediatrics?** \_\_\_\_\_

*By signing below, I hereby authorize Hometown Pediatrics to treat the above patient. I also authorize payment of medical benefits, and release of correspondence and/or medical records to other medical providers involved in your child's care. I have read and understand the Hometown Pediatrics Financial Policy.*

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

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_ rev 6/11

# Hometown Pediatrics

## FINANCIAL POLICY

Welcome and thank you for choosing Hometown Pediatrics for the medical needs of your child. We are dedicated to providing the best possible care for your child, and we want you to completely understand our financial policies. Our professional fees have been determined through careful consideration, in addition to being reasonable and customary within our geographical area. The following is a list of guidelines that are necessary in order to continue to provide high quality care and make your child's visit as pleasant as possible.

**Appointments:** Please inform our receptionist at the time of making your appointment of any demographic changes (e.g. address, telephone number, insurance, etc.). Failure to notify us immediately of changes in demographic information, financial status and/or insurance coverage may result in you being responsible for any service not covered by your insurance carrier.

**Self-pay Accounts:** Patients with no insurance will be expected to pay at the time of service. If you will not be able to pay in full, you must contact our billing department prior to seeing the doctor to make payment arrangements.

**Co-pays:** The patient is expected to present an insurance card at each visit. All co-payments and past-due balances are due and payable at the time of service.

**Insurance:** If we participate with your plan, we will directly bill your insurance. Keep in mind that your insurance policy is basically a contract between you and your insurance company. Not all insurance plans cover all services.

In the event your insurance plan determines a service to be "not covered," you will be responsible for those charges.

Payment is due upon receipt of a statement from our office within 30 days.

**Referrals:** It is the responsibility of the patient to know their insurance plan's procedures for referrals. If your plan requires a referral, it will be necessary for you to inform us of that prior to you scheduling an appointment with a specialist. We kindly ask that you notify our office 5 (five) business days prior to non-urgent referral visits.

**Late Arrival:** As a courtesy, please arrive at least 5 minutes prior to your appointment. If you are **more than 20 minutes late**, it may be necessary to re-schedule your appointment to another day in order to prevent inconveniencing other patients.

**No-Shows or Missed Appointments:** When an appointment is scheduled with the doctor, time is specifically allocated for you. When an appointment is not canceled in advance and the patient "no shows", another patient that needed to be seen may have been unable to because the time slot was already taken. We understand there may be times when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel your appointment. We wish to advise you that all appointments will require a 24-hour notice of cancellation by you. **If an appointment is missed without 24-hours prior notice, you will be charged a \$25.00 fee.** This includes appointments made on the same day or on the day prior. This fee is not payable by your insurance company and will be your responsibility.

**Child Custody/Divorce Cases:** This office will not bill a divorced spouse for the patient's service. It will be the responsibility of the parent or guardian that brings the child in for all co-pays, deductibles or balances. It is the parents' obligation to work out agreement themselves or through the court system.

**Late Fee Charge:** The office reserves the right to charge a 1.5% late fee on all unpaid balances that are 60+ days overdue. This will accumulate on balances only until paid in full.

**I have read, understand and agree to the above Hometown Pediatrics Financial Policy. I also understand and agree that such terms may be amended by the practice at any given time.**

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

Date: \_\_\_\_\_ Name of Patient: \_\_\_\_\_ Patient d.o.b.: \_\_\_\_\_

# Hometown Pediatrics

## Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I, \_\_\_\_\_, understand that as part of my child's healthcare, Hometown Pediatrics originates and maintains paper and/or electronic medical records describing my child's health history, symptoms, examination, test results, diagnoses, treatments and plans for future care or treatment. I understand that this information serves as:

- A basis for planning my child's care and treatment
- A means of communication among the many health professionals who contribute to their care
- A source of information for applying my diagnosis and/or surgical information to my bill
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that a more complete description of information uses and disclosures is available within Hometown Pediatrics' *Notice of Information Practices* which is available for review upon request. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations

I understand that Hometown Pediatrics, P.A. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Hometown Pediatrics reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Hometown Pediatrics change their notice, I will be notified of such.

I wish to have the following restrictions to the use or disclosure of my health information:

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I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and accept the terms of this consent. Signature: X \_\_\_\_\_

Printed Name: \_\_\_\_\_ Relationship to patient: (circle one) **Father** **Mother** **Guardian**

Date: \_\_\_\_\_ Name of Patient: \_\_\_\_\_ Patient d.o.b.: \_\_\_\_\_

# Hometown Pediatrics

## PEDIATRIC HISTORY

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Allergies to Meds \_\_\_\_\_

| Pregnancy Complications               |            |           |
|---------------------------------------|------------|-----------|
| <i>(check Yes or No)</i>              | <u>Yes</u> | <u>No</u> |
| Pregnancy less than 9 months          | _____      | _____     |
| High blood pressure                   | _____      | _____     |
| Gestational diabetes                  | _____      | _____     |
| Medications <i>(if yes, list)</i>     | _____      | _____     |
| _____                                 |            |           |
| _____                                 |            |           |
| <i>(check Yes or No)</i>              | <u>Yes</u> | <u>No</u> |
| Bleeding <i>(if yes, which month)</i> | _____      | _____     |
| Serious illnesses                     | _____      | _____     |
| Serious infections                    | _____      | _____     |
| Previous miscarriages                 | _____      | _____     |
| C-section <i>(if yes, why?)</i>       | _____      | _____     |
| _____                                 |            |           |

| Birth History                   |                         |
|---------------------------------|-------------------------|
| Place of birth:                 | _____                   |
| Birth weight:                   | _____ Length _____      |
| Length of labor:                | _____                   |
| Adopted:                        | No ___ Yes ___          |
| Birth Problems                  |                         |
| <i>(check Yes or No)</i>        | <u>Yes</u> <u>No</u>    |
| Jaundice                        | _____                   |
| Breathing problems              | _____                   |
| Antibiotics                     | _____                   |
| Other problems <i>(explain)</i> | _____                   |
| _____                           |                         |
| Breastfed:                      | _____ Formula fed _____ |

| Developmental History         |                              |
|-------------------------------|------------------------------|
| At what AGE did your child... | <u>Yes</u> <u>No</u>         |
| Smile: _____                  | School Problems? _____       |
| Roll over: _____              | _____                        |
| Sit alone: _____              | _____                        |
| Walk alone: _____             | 1st word with meaning: _____ |
| Bladder trained: _____        | Use 3 word sentence: _____   |
| Bowel trained: _____          | Ride tricycle: _____         |
| _____                         | Tie shoes: _____             |

| Medications Child Takes Routinely: | Hospitalizations & Operations: |
|------------------------------------|--------------------------------|
| _____                              | 1 _____ Date _____             |
| _____                              | 2 _____ Date _____             |
| _____                              | 3 _____ Date _____             |

| Childhood Illnesses          |            |           | Other Serious Illnesses |
|------------------------------|------------|-----------|-------------------------|
| <i>(check Yes or No)</i>     | <u>Yes</u> | <u>No</u> | <u>Date(s)</u>          |
| Allergies                    | _____      | _____     | _____                   |
| Asthma                       | _____      | _____     | _____                   |
| Bed wetting                  | _____      | _____     | 1. _____                |
| Chickenpox                   | _____      | _____     | 2. _____                |
| Convulsions/epilepsy         | _____      | _____     | 3. _____                |
| Diabetes                     | _____      | _____     | 4. _____                |
| Kidney disease               | _____      | _____     | 5. _____                |
| Measles                      | _____      | _____     | _____                   |
| Meningitis                   | _____      | _____     | _____                   |
| Mumps                        | _____      | _____     | _____                   |
| Pneumonia                    | _____      | _____     | _____                   |
| Rheumatic fever              | _____      | _____     | _____                   |
| Scarlet fever                | _____      | _____     | _____                   |
| Sickle cell trait or disease | _____      | _____     | _____                   |
| Whooping cough               | _____      | _____     | _____                   |

# Hometown Pediatrics

## PEDIATRIC HISTORY (Continued)

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

| Child's Family  | Family History   |                  |   |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
|---|------------------|------------------|---|---|---------------------------|---------|-------|-------|---------------------------|-------|---------|-------|-------------------------|-------|-------|-------|---|---------------|------------|-------|---------|-------|------------|-------|-------|---------|-------|------------|-------|-------|---------|-------|------------|-------|-------|---------|-------|------------|-------|-------|---------|-------|------------|-------|-------|---------|-------|------------|-------|-------|---------|-------|------------|-------|-------|--|--|-----------------|-----------------|--|-------------|-------------|--------------------------------------|--|--|----------|-------|-------|---------------|-------|-------|--------------|-------|-------|--------|-------|-------|--------|-------|-------|--------------|-------|-------|-------|-------|-------|-----------|-------|-------|---------|-------|-------|---------|-------|-------|----------------|-------|-------|------------------|-------|-------|-------------|-------|-------|-------------------|-------|-------|------------|-------|-------|-----------|-------|-------|-----------|-------|-------|--------|-------|-------|--------------|-------|-------|--------------|-------|-------|
| <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;"></td> <td style="width: 20%; text-align: center;"><u>full name</u></td> <td style="width: 10%; text-align: center;"><u>Age</u></td> <td style="width: 30%; text-align: center;"><u>Present Health<br/>or cause of death</u></td> <td style="width: 10%;"></td> </tr> <tr> <td>Mother:</td> <td>_____</td> <td>_____</td> <td>_____</td> <td></td> </tr> <tr> <td>Father:</td> <td>_____</td> <td>_____</td> <td>_____</td> <td></td> </tr> <tr> <td></td> <td style="text-align: center;"><u>full name</u></td> <td style="text-align: center;"><u>circle</u></td> <td style="text-align: center;"><u>DOB</u></td> <td></td> </tr> <tr> <td>Sib #1:</td> <td>_____</td> <td style="text-align: center;"><i>M F</i></td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Sib #2:</td> <td>_____</td> <td style="text-align: center;"><i>M F</i></td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Sib #3:</td> <td>_____</td> <td style="text-align: center;"><i>M F</i></td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Sib #4:</td> <td>_____</td> <td style="text-align: center;"><i>M F</i></td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Sib #5:</td> <td>_____</td> <td style="text-align: center;"><i>M F</i></td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Sib #6:</td> <td>_____</td> <td style="text-align: center;"><i>M F</i></td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Sib #7:</td> <td>_____</td> <td style="text-align: center;"><i>M F</i></td> <td>_____</td> <td>_____</td> </tr> </table> |                  | <u>full name</u> | <u>Age</u>                                  | <u>Present Health<br/>or cause of death</u> |                           | Mother: | _____ | _____ | _____                     |       | Father: | _____ | _____                   | _____ |       |       | <u>full name</u>                        | <u>circle</u> | <u>DOB</u> |       | Sib #1: | _____ | <i>M F</i> | _____ | _____ | Sib #2: | _____ | <i>M F</i> | _____ | _____ | Sib #3: | _____ | <i>M F</i> | _____ | _____ | Sib #4: | _____ | <i>M F</i> | _____ | _____ | Sib #5: | _____ | <i>M F</i> | _____ | _____ | Sib #6: | _____ | <i>M F</i> | _____ | _____ | Sib #7: | _____ | <i>M F</i> | _____ | _____ | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;"></td> <td style="width: 10%; text-align: center;"><u>Mother's</u></td> <td style="width: 20%; text-align: center;"><u>Father's</u></td> </tr> <tr> <td></td> <td style="text-align: center;"><u>Side</u></td> <td style="text-align: center;"><u>Side</u></td> </tr> <tr> <td colspan="3"><i>(Check if disease is present)</i></td> </tr> <tr> <td>Diabetes</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Heart trouble</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Heart attack</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Stroke</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Cancer</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Tuberculosis</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Ulcer</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Arthritis</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Obesity</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Suicide</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Mental Illness</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Thyroid problems</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Sickle cell</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Seizures/epilepsy</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Bedwetting</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Allergies</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Hay fever</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Asthma</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Other: _____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Other: _____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </table> |  | <u>Mother's</u> | <u>Father's</u> |  | <u>Side</u> | <u>Side</u> | <i>(Check if disease is present)</i> |  |  | Diabetes | _____ | _____ | Heart trouble | _____ | _____ | Heart attack | _____ | _____ | Stroke | _____ | _____ | Cancer | _____ | _____ | Tuberculosis | _____ | _____ | Ulcer | _____ | _____ | Arthritis | _____ | _____ | Obesity | _____ | _____ | Suicide | _____ | _____ | Mental Illness | _____ | _____ | Thyroid problems | _____ | _____ | Sickle cell | _____ | _____ | Seizures/epilepsy | _____ | _____ | Bedwetting | _____ | _____ | Allergies | _____ | _____ | Hay fever | _____ | _____ | Asthma | _____ | _____ | Other: _____ | _____ | _____ | Other: _____ | _____ | _____ |
|   | <u>full name</u> | <u>Age</u>       | <u>Present Health<br/>or cause of death</u> |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| Mother:   | _____            | _____            | _____                                       |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| Father:   | _____            | _____            | _____                                       |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
|   | <u>full name</u> | <u>circle</u>    | <u>DOB</u>                                  |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| Sib #1:   | _____            | <i>M F</i>       | _____                                       | _____                                       |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| Sib #2:   | _____            | <i>M F</i>       | _____                                       | _____                                       |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| Sib #3:   | _____            | <i>M F</i>       | _____                                       | _____                                       |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| Sib #4:   | _____            | <i>M F</i>       | _____                                       | _____                                       |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| Sib #5:   | _____            | <i>M F</i>       | _____                                       | _____                                       |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| Sib #6:   | _____            | <i>M F</i>       | _____                                       | _____                                       |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| Sib #7:   | _____            | <i>M F</i>       | _____                                       | _____                                       |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
|   | <u>Mother's</u>  | <u>Father's</u>  |   |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
|   | <u>Side</u>      | <u>Side</u>      |   |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| <i>(Check if disease is present)</i>  |                  |                  |   |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| Diabetes  | _____            | _____            |   |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| Heart trouble   | _____            | _____            |   |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| Heart attack  | _____            | _____            |   |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| Stroke  | _____            | _____            |   |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| Cancer  | _____            | _____            |   |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| Tuberculosis  | _____            | _____            |   |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| Ulcer   | _____            | _____            |   |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| Arthritis   | _____            | _____            |   |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| Obesity   | _____            | _____            |   |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| Suicide   | _____            | _____            |   |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| Mental Illness  | _____            | _____            |   |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| Thyroid problems  | _____            | _____            |   |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| Sickle cell   | _____            | _____            |   |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| Seizures/epilepsy   | _____            | _____            |   |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| Bedwetting  | _____            | _____            |   |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| Allergies   | _____            | _____            |   |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| Hay fever   | _____            | _____            |   |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| Asthma  | _____            | _____            |   |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| Other: _____  | _____            | _____            |   |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| Other: _____  | _____            | _____            |   |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| <p><b>Social History</b></p> <p style="text-align: center;"><i>(Check "No" or "Yes")</i></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;"></td> <td style="width: 10%; text-align: center;"><u>No</u></td> <td style="width: 10%; text-align: center;"><u>Yes</u></td> <td style="width: 20%; text-align: center;"><u>No./day</u></td> </tr> <tr> <td>This teen patient smokes?</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>This teen patient drinks?</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Household with smokers?</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Pets? <i>(If "Yes", please list...)</i></td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </table>   |                  | <u>No</u>        | <u>Yes</u>                                  | <u>No./day</u>                              | This teen patient smokes? | _____   | _____ | _____ | This teen patient drinks? | _____ | _____   | _____ | Household with smokers? | _____ | _____ | _____ | Pets? <i>(If "Yes", please list...)</i> | _____         | _____      | _____ |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
|   | <u>No</u>        | <u>Yes</u>       | <u>No./day</u>                              |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| This teen patient smokes?   | _____            | _____            | _____                                       |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| This teen patient drinks?   | _____            | _____            | _____                                       |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| Household with smokers?   | _____            | _____            | _____                                       |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |
| Pets? <i>(If "Yes", please list...)</i>   | _____            | _____            | _____                                       |   |                           |         |       |       |                           |       |         |       |                         |       |       |       |   |               |            |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |         |       |            |       |       |  |  |                 |                 |  |             |             |                                      |  |  |          |       |       |               |       |       |              |       |       |        |       |       |        |       |       |              |       |       |       |       |       |           |       |       |         |       |       |         |       |       |                |       |       |                  |       |       |             |       |       |                   |       |       |            |       |       |           |       |       |           |       |       |        |       |       |              |       |       |              |       |       |

**Notes:**

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# Hometown Pediatrics

1595 Lake Front Circle  
The Woodlands, TX 77380

(281) 292-8980 (Office)

(281) 292-8070 (Fax)

Kristie R. Chandler, MD, FAAP Tony John, MD, FAAP Mona A. Smith, MD, FAAP Michael T. Wright, MD, FAAP

## AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

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

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

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**

**281-292-8980 (Office) 281-292-8070 (Fax)**

***...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 6/11 Relationship to Patient (circle one) : ***self mother father guardian*** Date: \_\_\_\_\_