Hometown Pediatrics

1595 Lake Front Circle

(281) 292-8980 (Office) **The Woodlands, TX 77380** **(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 <u>from</u>: ***Name of Medical Practice, Physician, Clinic or Hospital***

Address _____

City, State, Zip _____

Phone Number _____ Fax _____

…to be released <u>to</u>:

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

<u>or</u> ☐ medical records ***limited to the following specific types of information***:

_____

<u>Also,</u> 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 _____

Relationship to Patient*:* ☐***self*** ☐***mother*** ☐***father*** ☐***guardian*** **Date:** _____

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