Hometown Pediatrics
1595 Lake Front Circle
The Woodlands, TX 77380

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

Kristie R. Chandler, MD, FAAP **Amanda E. Hathaway, MD, FAAP** **Tony John, MD, FAAP**
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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:

Hometown Pediatrics, P.A.
1595 Lake Front Circle
The Woodlands, TX 77380-3604
281-292-8980 (Office) 281-292-8070 (Fax)

…to be released to:

_____
Name of Medical Practice, Physician, Facility or Company

Address _____

City, State, Zip _____

Phone Number _____

…for the purpose of:

☐ ***proof of immunization*** ☐ ***insurance review or underwriting***
☐ ***legal matters*** ☐ ***continuing or transfer of medical care***

If you are leaving Hometown Pediatrics, please let us know why: _____

_____

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

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

Relationship to Patient: ☐ ***self*** ☐ ***mother*** ☐ ***father*** ☐ ***guardian*** **Date: X** _____ *rev 06/18*