Hometown Pediatrics

(281) 292-8980 (Office)

1595 Lake Front Circle
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>:

Hometown Pediatrics, P.A.
1595 Lake Front Circle
The Woodlands, TX 77380-3604

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

…to be released <u>to</u>:

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***:

____

<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 <u>Printed</u> Name ____________________________ **Signature: X** ___________________________________

Relationship to Patient (circle one) **:** ***self mother father guardian*** **Date: X** ___________________________ *rev 06/18*