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 <u>from</u>: | ***Name of Medical Practice, Physician, Clinic or Hospital***

Address _____

City, State, Zip _____

Phone Number _____

…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 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 <u>Printed</u> Name: _____ **Signature: _____**

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