Hometown
PEDIATRICS

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Childs Name: _____ Date of Birth: _____

I do hereby authorize my child's medical records **from:**

_____
Name of Medical Practice, Physician, Clinic, or Hospital

_____

Address: _____

Phone: _____

…to be release **to:**

Hometown Pediatrics, PA
1595 Lake Front Circle
The Woodlands, TX 77380-3604
Phone: (281)-292-8980 Fax: (281)-292-8070

…for the purpose of: ☐ continuing or transfer of medical care ☐ proof of immunizations
☐ insurance review or underwriting ☐ legal matter

Release information concerning the following dates: from: _____ to _____
☐ Comple Medical Record
☐ Limited Medical Record – Please include the specific items: _____

I ☐DO or ☐ DO NOT consent to the 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.

Date: _____ Parent/Guardian Name: _____

Signature: _____