AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name _____ **Date of Birth** _____

Social Security#_____ **Date(s) of service. If all dates of service, write "all"** _____

Pediatric & Adolescent Center of NW Houston, P.A.
www.pedsofnwh.com
455 School Street, Ste 26
Tomball, TX 77375
P: 281-374-9700 F: 281-370-8765

☐ **I authorize the above named organization to release my medical records to:**

☐ **I authorize the above named organization to receive records from:**

_____
Person or Organization

_____
Address

_____
Phone Fax (if applicable)

This information is being released for the following purposes:
☐ Continued Care ☐ Attorney / Litigation ☐ Insurance ☐ Disability ☐ Other _____

INFORMATION TO BE RELEASED:
☐ **All** Medical Records ☐ Consultation/History and Physical Exam ☐ Billing Records ☐ Progress/Visit Notes ☐ Immunization Record
☐ Radiology Reports ☐ Diagnostics / Labs ☐ Other (Specify)_____

- I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.
- I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS or HIV; behavioral or mental health services, and treatment for alcohol and drug abuse.
- I understand that I have a right to revoke this authorization at any time in writing and will present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. This authorization expires 180 days from the date of my signature unless specified in writing here: _____
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
- **To the party receiving this information**: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

_____ _____ _____
Signature of Patient or Legal Representative Print Name Date

_____
Relationship to Patient (If Legal Representative)