AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION

Patient Name (please print) _____ Date of Birth _____

Patient's Address _____ Telephone # _____

I,_____, hereby authorize the use and/or disclosure of protected health information [PHI].
(parent/guardian/patient)

To: **Texas Family Pediatric Group, PA**

☐ **4855 Riverstone Blvd. Ste. 106**
Missouri City, TX 77459
(281) 208-9503 Fax: (281) 208-9504

☐ **16545 Southwest Freeway. Ste. 210**
Sugar Land, TX 77479
(281)240-8384 Fax (281)240-8377

From: Dr's Name/Person/Organization: _____

Address: _____

City,State,ZipCode: _____

Telephone: _____ **Fax:** _____

I specifically authorize the use and disclosure of the following PHI:

- ○ Dates of service_____
- ○ Consult Records _Immunization Record
- ○ Laboratory Reports _Radiology Reports
- ○ ADHD Reports _Entire Medical Record

I understand that the information in my record may include information relating to sexually transmitted diseases which may include, but are not limited to diseases such as hepatitits, syphilis, gonorrhea, the human immunodefiency virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS). It may also inlcude information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information will be used for:

- ○ Consultaion _ Continuing Care
- ○ Insurance _ Legal
- ○ Personal _Second Opinion
- ○ Other:_____

I understand that I can revoke or terminate this authorization by submitting a written revocation to the address listed above except to the extent that disclosure made in good faith has already occurred in reliance on this consent . Without prior revocation, this authoization will automaically expire six months from this date. If I have questions about disclosure of my health information.I can contact the office # provided above.

If neither federal nor Texas privacy law apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Texas privacy law.

_____ _____
Signature of Patient or Legal Representative Print Name

_____ _____
Relationship to Patient (If legal Representative) Date