AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name_____Date of Birth_____

I hereby authorize _____

_____

_____ to disclose the above individual's PHI as described below:

Description of PHI to be released: (check all that apply)

Date(s) of Service Requested (if known) _____

_____ Consultation Reports_____Entire Medical Record _____ Immunizations Records

_____ Laboratory Reports _____ Radiology/Imaging Reports_____ Other_____

I understand that the PHI in my health record may include information relating to communicable disease. Acquired Immunodeficiency Syndrome ("AIDS"), or Human Immunodeficiency Virus ("HIV"), behavioral or mental health/alcohol/drug/substance abuse or any such related information. This PHI may be disclosed to and used by the following individual or organization:

Name:_____Address:_____City_____St_____Zip_____

Description for the purpose of the use and or disclosure:

Consultation _____ Continuing Care _____ Insurance _____

Legal Purpose _____ Personal _____ Second Opinion _____

Other: Please describe: _____

I understand I may inspect or copy the PHI to be used or disclosed. I understand that PHI used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and may no longer be protected by federal and state privacy regulations. I understand the Pediatric Center may charge a processing fee for this service. I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify.

I understand I may revoke this authorization at any time by notifying the Health Information Department at Pediatric Center. I understand that if I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Signature of Parent or Legal Guardian_____

Contact Phone Number_____

Relationship to Patient_____

Date_____

We will no longer be able to accept hand written requests or a request from another office that is not HIPAA Compliant. In this case we will need to send you a copy of our request and ask that it be filled out and signed.

1300 Main Street
Richmond, Texas 77469
Phone: 281-341-9696 • Fax: 281-341-6218

4911 Sand Hill Drive • Suite A
Sugar Land, Texas 77479
Phone: 281-277-6633 • Fax: 281-277-6744