



Children's Medical Group, P.A.

**AUTHORIZATION FOR RELEASE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

Indicate the name of the physician, hospital, medical center, or lab that you are requesting records from:

Name of entity to release information

Phone number

Address

City/State/Zip

I am requesting that the medical information for the patient names listed below be transferred to:

**Children's Medical Group
1912 W. 35th Street
Austin, TX 78703**

Please release the following information:

- | | | |
|--|--|--|
| <input type="checkbox"/> Problems List | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Immunization Record |
| <input type="checkbox"/> History & Physical Exam | <input type="checkbox"/> Medications | <input type="checkbox"/> Specialists Reports |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Other (specify) |

This information is necessary for the following purpose:

- | | | |
|--|---|--|
| <input type="checkbox"/> Continue Patient Care | <input type="checkbox"/> Insurance | <input type="checkbox"/> Other (specify) |
| <input type="checkbox"/> Personal use | <input type="checkbox"/> Attorney/Legal | |

I understand that the information in my child's health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Name: _____ Date of Birth _____

Name: _____ Date of Birth _____

Name: _____ Date of Birth _____

Signed: _____
Signature of Patient or Legal Guardian Relationship to Patient Date

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION