Children's Medical Group, PLLC

Authorization for Release and Disclosure of Protected Health Information

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

_____

Name of Entity to release information

_____ _____

Phone Number Fax Number

_____

Address

_____

City/State/Zip

I am requesting that the medical information for the patients named below be transferred to:

Children's Medical Group
631 W 38th St STE 3
Austin, TX 78705

Please release the following information:

___ Problems List ___ Lab Reports ___ Immunization Record
___ History & Physical Exam ___ Medication List ___ Specialist Reports
___ Progress Notes ___ Radiology Reports ___ Other (specify) _____
_____

This information is necessary for the following purpose:

___ Continued Patient Care ___ Insurance ___ Other (specify) _____
___ Personal Use ___ 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.

Patient Name _____ DOB _____
Patient Name _____ DOB _____
Patient Name _____ DOB _____

_____ _____ _____

Signature of Patient or Legal Guardian Relationship to Patient Date

Patient/Guardian to be Provided with a signed copy of authorization