Authorization Release of Medical Records

I hereby authorize the release of medical record information of:
Patient Name: ________________________________ Date of Birth:________________________

Address/City/State/Zip:____

Phone #:______________________________

From:
Physician Name:_______________________ Office Name:__________________________

Address:_______________________________ City/State/Zip:________________________

Phone #:_______________________________ Fax #________________________________

TO: Pedi Place @ Westover Hills
3207 Rogers Road
San Antonio, Texas 78251
210.680.7334 phone
210.680.7337 fax

I understand there may be a charge for my record, as permitted by Texas law.

Include this information (if applicable): __ alcohol/drug __Genetics __ HIV/AIDS __ Mental Health

Purpose of record; __ Continued Care __ Insurance __ Personal Use __ Attorney/Legal

Information to be released: ______Complete medical record _____ Items as indicated below

______ Progress Notes ______ Problem List ______ Consultations
______ Lab Reports ______ X-ray Reports ______ Immunizations
______ Medication List ______ H&P ______ Mental Health Records
______ Other specify:_______________________________

In accordance with state law and regulatory agency requirements, the health record is the property of **PEDI PLACE @ WESTOVER HILLS**. By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed.

Prohibition on re-disclosure: This information is being disclosed from records whose confidentiality is protected by state and federal law. These laws prohibit any further re-disclosure without specific consent of the patient or legal guardian/representative. I may revoke my authorization at any time with written notice. This authorization will expire 180 days from date indicated below.

_____________________________________ _____________________________________
Parent, guardian or legal representative **Date**

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.