Children's Medical Group, PLLC

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Indicate the name of the Physician/Hospital/Medical Center/Lab that you are requesting records from:

Name of entity to release information:_____
Phone number:_____
Address:_____

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

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

Please release the following information:

__ Problems List
__ Lab Reports
__ Immunization Record
__ Medications
__ Specialists Reports
__ Progress Notes
__ Radiology Reports
__ Other (specify)
__ History & Physical Exam
__ All medical records

This information is necessary for the following purpose:

__ Continue 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.

Name: _____ Date of Birth _____

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

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