beansprout PEDIATRICS

Authorization for the Release or use of Protected Health Information

PATIENT INFORMATION

_____ _____

patient name date of birth

_____

address city state zip phone

Reason for needing medical records? _____

RELEASE THE FOLLOWING ◯ complete medical records ◯ vaccine records only

◯ other _____

◯ **FROM** ◯ **TO**

_____

practice/physician

_____

address

_____

city state zip

_____

phone fax

◯ **FROM** ◯ **TO**

Beansprout Pediatrics

Bee Cave • Dripping Springs

Attention: Medical Records:

2440 E. Highway 290, Bldg C
Dripping Springs, TX 78620
p: 512.610.7030 extension 2
fax: 512.610.7034

*$30. Fee for complete medical record from Beansprout

Authorizing the disclosure of this healthcare information is voluntary. I do not need to sign this form in order to assure treatment or payment. I can cancel this authorization any time with written notification to Beansprout Pediatrics. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled. Any disclosure of information carries with it the potential for further releases or distribution by the recipient that may not be protected by confidentiality laws. This authorization will expire 90 days from the date signed below unless another date or event is entered here. As parent/guardian of above listed patient, my signature below is my informed consent to release his/her medical records.

_____ _____

parent/guardian signature date

_____ _____

printed name relationship to patient