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 ______________