AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Name of Patient: _____ DOB: _____

Address: _____ Phone No.: _____

I hereby authorize physicians and representatives of Pediatric Healthcare of Northwest Houston, PA:

- □ 27721 State Highway 249, Suite 100 ● Tomball, TX 77375 ● office (281) 357-5115 fax (281) 516-9466
- □ 11840 FM 1960 West ● Houston, TX 77065 ● office (832) 912-7044 fax (832) 912-7033
- □ 12015 Louetta Road, Suite 100 ● Houston, TX 77070 ● office (281) 664-2152 fax (281) 257-3514
- □ 690 S Loop 336 West Suite 110 ● Conroe, TX 77304 ● office (936) 539-8190 fax (936) 756-9948

For Entire Records Request, please fax request to (832) 912-7033

o **To release confidential information to** o **To obtain confidential information from**

Name: _____

Address: _____

Phone: _____ Fax: _____

REASON FOR DISCLOSURE:
Please check only one:

- o **Treatment/Continuing Medical Care**
- o **Personal Use**
- o **Insurance**
- o **Legal Purposes**
- o **Disability Determination**
- o **School**
- o **Employment**
- o **Other**

THE FOLLOWING INFORMATION WILL BE:
Please check one: o **Released** o **Obtained**

- o **Entire Records exclude Mental Health**
- o **Immunization Records**
- o **Diagnostic Test Results**
- o **Hospital Records**
- o **Mental Health Records**
- o **Other _____**

EFFECTIVE TIME PERIOD: I understand this authorization is valid for 90 days from the date signed.
FEES: I understand you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information will be charged according to rulings set forth by the Texas State Board of Examiners.
RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named on this request. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.
SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health and Safety Code§ 181.154© and/or 45 C.F.R § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Signature:_____Date:_____

Printed Name:_____Relationship to Patient:_____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol, substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003)

Signature of Minor Individual:_____Date:_____