Hometown Pediatrics
1595 Lake Front Circle
(281) 292-8980 (Office) **The Woodlands, TX 77380** **(281) 292-8070 (Fax)**

Kristie R. Chandler, MD, FAAP **Mona A. Smith, MD, FAAP**
Sarah E. Moore, MD, FAAP **Tony John, MD, FAAP**

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Child's First & Last Name: ______________________ Date of Birth: ______________________

Child's First & Last Name: ______________________ Date of Birth: ______________________

Child's First & Last Name: ______________________ Date of Birth: ______________________

Child's First & Last Name: ______________________ Date of Birth: ______________________

I do hereby authorize my child's medical records to:

Name of Medical Practice, Physician, Clinic or Hospital

Address ______________________

City, State, Zip ______________________

Phone Number ______________________ Fax ______________________

...to be released from:

Hometown Pediatrics, P.A.
1595 Lake Front Circle
The Woodlands, TX 77380-3604

281-292-8980 (Office) **281-292-8070 (Fax)**

...for the purpose of: ☐ ***continuing or transfer of medical care*** ☐ ***proof of immunization*** ☐ ***insurance review or underwriting*** ☐ ***legal matters***

Release information concerning the ***following dates***: from ____________ to __________, and to include:

☐ ***immunization record*** – no charge

☐ ***medical summary*** (includes immunizations & a summary of each visit) – no charge

☐ ***complete medical records*** to include immunizations, illness(es) and/or treatments

(Note: In accordance with limits set by the TSBME, a fee of $25.00 for the first 20 pages & $.50 cents per each additional page is charged for copying, mailing, or otherwise complying with any approved request for the release of medical records)

☐ medical records ***limited to the following specific types of information***:

____

Also, I ☐**DO** or ☐**DO NOT** (*check one & initial* ________) consent to release of information relating to psychiatric or psychological testing or treatment, biofeedback training, alcohol &/or drug abuse diagnosis/treatment, or HIV (AIDS) testing

I, the parent/guardian, agree that ***a photocopy or facsimile (fax) of this authorization may be considered valid***, this authorization shall be ***valid for 120 days from the date of signature***, and that ***this authorization can be revoked in writing at any time prior to the expiration date***.

I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless Hometown Pediatrics, PA from all liability and damage resulting from the lawful release of my Protected Health Information.

Parent/Guardian Printed Name ______________________ **Signature:** X ______________________

Relationship to Patient *(circle one)*: ***self mother father guardian*** **Date:** ______________________

Rev 7/15