



www.abcdpediatrics.com

19238 Stonehue
San Antonio, TX 78258
P: 210-494-2223
F: 210-494-2631

2200 Roy Richard Dr.
Schertz, TX 78154
P: 210-566-4777
F: 210-566-4779

2115 Stephens Place, #900
New Braunfels, TX 78130
P: 830-214-6708
F: 830-358-7711

121 Bulverde Crossing, #100
Bulverde, TX 78163
P: 210-499-6400
F: 210-494-2631

Authorization to Release or Disclose Protected Health Information

Patient's Name: _____ Date of Birth: ____/____/____ Date of Request: _____

Address: _____ Day Time Ph: (____) _____
(Street, city, state, zip code)

Please list where ABCD Pediatrics is to request medical records FROM:

Facility/Office: _____ Fax Number: _____

Address: _____ Phone Number: _____

City, State: _____

Dates of Service: _____ Reason for request: _____

The following information is to be disclosed to ABCD Pediatrics: (Please send ONLY the information listed below.)

List of records to be sent:

- | | | | |
|--------------|----------------------|------------------------------|-----------------|
| Problem List | Immunization Record | Medication List | Last Well Visit |
| Growth Chart | Drug Allergy History | ADHD History (if applicable) | |

Please send ONLY THE REQUESTED INFORMATION via fax to ABCD Pediatrics: (Circle One)

Stone Oak: 210-494-2631

Schertz: 210-566-4779

New Braunfels: 830-358-7711

Bulverde: 210-494-2631

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing, and I understand the revocation will not apply to information already released based on this authorization.

Other Rights: a) I understand that authorizing the disclosure of this health information is voluntary and that I may refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I do not specify an expiration date, event or condition, this authorization will expire in six months from date signed.

By signing this form, I understand and accept full responsibility for the medical records I am requesting. I relinquish ABCD Pediatrics of any and all accountabilities concerning these medical records.

Signature of patient or legal representative

Date

If signed by legal representative, relationship to patient

Our Mission: To provide caring and informed attention to your children's health and wellbeing as they grow and thrive into adulthood.