ABCD Pediatrics

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 send medical records TO:

Facility/Office: _____ Fax Number: _____

Address: _____ Phone Number: _____

City, State: _____

Dates of Service: _____ **Reason for request**: _____

The following information is to be disclosed by ABCD Pediatrics: (Please check one box for each item)

Type of Records Requested:

☐ Problem List ☐ Immunization Record ☐ Medication List ☐ Well Visits
☐ Growth Chart ☐ Drug Allergy History ☐ ADHD History (if applicable)
OR
☐ Complete Record

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.