ABCD Pediatrics

www.abcdpediatrics.com

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

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

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

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

Boerne Office
124 E. Bandera Rd, #304
Borne, TX 78006
P: 830-816-5055
F: 830-816-5056

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 or where you would like us to request records FROM:

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 if not requesting complete record.)**

❑**The following information is to be sent to ABCD Pediatrics: (Please check one box for each item if not requesting complete record.)**

❑ Complete Record ❑ Well Visits ❑ Growth Chart ❑ Immunization Record ❑ Drug Allergy History
❑ Well Visits ❑ Problem List ❑ ADHD History ❑ Medication List

If you are wishing to have your records sent to ABCD Pediatrics:

Please list which ABCD Pediatrics location you would like your records sent TO:

❑ Stone Oak Office **(FAX: 210-494-2631)** ❑Schertz Office **(FAX: 210-566-4779)** ❑New Braunfels Office **(FAX: 830-358-7711)**

❑ Bulverde Office **(FAX: 210-494-2631)** ❑Boerne **(FAX: 830- 816-5056)**

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

Best Care. Every Patient. All the Time