

www.abcdpediatrics.com

 19238 Stonehue
 2200 Roy Richard Dr.
 2115 Stephens Place, #900

 San Antonio, TX 78258
 Schertz, TX 78154
 New Braunfels, TX 78130

 P: 210-494-2223
 P: 210-566-4777
 P: 830-214-6708

 F: 210-494-2631
 F: 210-566-4779
 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 Bi	rth:/	_/ Date	of Request:	
Address:(Street, city, state			Day Time Ph: (_))	
Please list where <u>ABCD Pediatrics</u> 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	Medic	ation List	Usits	
Growth Chart	Drug Allergy History		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.