# Neighborhood Pediatrics

## 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 from:***
Name of Medical Practice, Physician, Clinic or Hospital_____
Address _____
City, State, Zip _____
Phone Number _____ Fax _____

***…to be released to:*** **Neighborhood Pediatrics, PLLC**
**19221 I-45 South, Suite 430**
**Shenandoah, TX 77385**
**Fax: 855-255-3870**

***…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:
☐ ***complete medical records*** in your possession to include illness(es) and/or treatments
**or** ☐ 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 and/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 Neighborhood Pediatrics, PLLC 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: _____**