

Authorization for Disclosure of Protected Health Information To Town Center Pediatrics

This completed form authorizes another provider to disclose or release a patient's protected health information to Town Center Pediatrics.

I. Patient's Name: _____ Birth Date: _____

Patient's Address: _____ Home Phone: _____

City, State, Zip: _____ Dates of Service: _____

II. Check the reports to be disclosed: (Please refer to copy fees on Instruction page.)

- | | |
|--|--|
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Billing Claims Forms |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Itemized Statement of Charges |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> All Information |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Other, specify: _____ |
| <input type="checkbox"/> Pathology Reports | |

Or, for mental health records (May require physician/psychologist approval):

- | | |
|--|--|
| <input type="checkbox"/> Psychiatric/Mental Health Records | <input type="checkbox"/> All information |
| <input type="checkbox"/> Neuropsychological Testing | <input type="checkbox"/> Other, specify: _____ |

III. Send the copies to: **Town Center Pediatrics** Phone: 281-494-2255

Mailing Address: **3521 Town Center Blvd South, Suite A, Sugar Land TX 77479**

IV. For the purpose of: _____

V. I authorize _____ (provider) to disclose the protected health information about myself (or the patient) as described above.

I understand:

- This authorization expires 180 days from the date of my signature unless I specify otherwise.
Expiration: _____
- I may revoke this authorization at any time by notifying the above provider in writing. If I revoke the authorization I understand that it will have no affect on actions the provider took in good faith before receiving the revocation.
- The information released may contain information related to AIDS or HIV infection; drug or alcohol abuse; mental or behavioral health or psychiatric care, except for psychotherapy notes.
- The above provider reserves the right to verify my identity/guardianship.
- I may be charged for the copies requested.
- I understand that the above provider may not condition treatment or payment on my completion of this form.

Signature: _____ Date _____

Printed Name: _____ Relationship to Patient: _____

Mail or deliver this form to the above Healthcare provider. (The Patient's current or previous provider.)