12822 Veterans Memorial Drive
Houston, TX 77014
Tele: (832) 779-3330
Fax: (832) 779-2475
RainbowPediatricsHouston.com

Medical Release Form

This form is used to obtain authorization to release protected health information from the custodial parent and/or legal guardian of minor (under the age of 18) patients. Patients who have reached the age of 18 must consent to and sign authorization for release of protected health information. Rainbow Pediatrics of Houston, PLLC may verify your identity/guardianship. Some requests may be subject to a reasonable fee.

I, _____ hereby authorize the release of protected health information for the following:

Patient Name:_____ Date of birth:_____

Address:_____

City:_____ State:_____ ZIP:_____

FROM: Doctor/Clinic/Hospital:_____

Address:_____

_____

Tele #: _____ Fax #: _____

TO: Doctor/Clinic/Hospital:_____

Address:_____

_____

Tele #: _____ Fax #: _____

Please release the following:

___ All health information (including growth charts and vaccination records)

Or Specifically (please check all that apply):

_____ History/Physical Exam/Progress Notes _____ Vaccine record _____Growth Charts
_____ Discharge Summary _____ Diagnostic Test Reports _____ Lab Results _____ Consultation Reports
_____ Radiology/Images _____ Pathology Reports _____ Other (specify): _____

_____

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I understand that these records may contain information related to the diagnosis and/or treatment of mental health illness, alcohol/substance abuse or dependency, HIV/AIDS testing and status, sexually transmitted disease diagnosis and other sensitive medical information of either my children, myself, or my child's other parent.

___ Yes, I consent to the release of this information.

___ No, I do not consent to the release of this information.

Purpose of disclosure is for treatment/ continuity of medical care.

I hereby release Rainbow Pediatrics of Houston, PLLC employees and agents from and any and all liabilities for fulfilling the authorization request for release of protected health information. I understand this authorization may be revoked in writing at any time except to the extent that action had been taken in reliance on it. Unless otherwise revoked, this authorization will remain valid until such time as it is revoked in writing. If the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. 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.

Signature:_____ Date: _____

Printed name:_____ Relationship to patient:_____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, Tex. Fam. Code §32.003).

Minor's Signature:_____ Date:_____