PRESTON HOLLOW
PEDIATRICS

Authorization for Release of Medical Information

Patient Name: _____ DOB: ____/____/_____

I, _____ hereby authorize the release of medical information **TO:**

Preston Hollow Pediatrics
7515 Greenville Ave, Ste 610
Dallas, TX 75231
Ph: (214) 643-8286 F: (214) 617-0328

FROM:
Doctor/Clinic/Hospital:_____

Address: _____

_____

Telephone: _____ Fax : _____

Please release the following:
___ **All health information (including growth charts and vaccination records)**
___ History/Physical Exam ___ Discharge Summary ___ Diagnostic Test Reports ___ Lab Results
___ Progress Notes ___ Consultation Reports ___ Radiology/Images ___ Pathology Reports
___Other (specify): _____

I consent to the release of information related to HIV/AIDS or infection with any other communicable diseases and informa#on related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical records

___ Yes, I consent to the release of this informa#on.
___ No, I do not consent to the release of this informa#on.

Purpose of disclosure:
___ Treatment/ Continuing medical care

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

Signature of Parent or Legal Guardian: _____ Date: ____/____/____ Print

Name: _____ Relationship to Patient: _____