



AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Child's First & Last Name: _____ Date of birth: _____

I hereby authorize my child's medical records from:

Name of Medical Practice, Physician, Clinic or Hospital

Address: _____

City, State, Zip _____

Phone Number _____

...to be released to:

Steeplechase Pediatric Center
21216 Northwest Fwy., Ste. 470
Cypress, Texas 77429
(281) 469-2838 office (281) 469-9314 fax

...for purpose of: _____ for continue of care _____ proof immunizations
_____ Insurance review _____ 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 limitations:

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 Steeplechase Pediatrics, from all liability and damages resulting from the lawful release of my protected health information.

Printed Name: _____ Signature: _____ Date _____

Relationship to patient (circle one): **self** **mother** **father** **guardian**