• Naheed Rahman, MD, F.A.A.P. • Mario Garza, Jr., MD, F.A.A.P. • Paul S. Herman, MD, F.A.A.P. • Veronica Goytia, MD, F.A.A.P. •
• Farah Mamedov, MD, F.A.A.P.• Grace C. Leonardo, MD, F.A.A.P. • Rosabelle McConkey, MD, F.A.A.P. •
• Margaret McPherson, MD, F.A.A.P • Mark Lorenzen, MD, F.A.A.P. • Tracey Y. Louie, MD, F.A.A.P. • Huda Battikhi, MD, F.A.A.P. •
• Sandy Nguyen, APRN, FNP-C • Tami Pogue, RN, MS, C-PNP • Kathy LeBeouf, RN, MSN, CPNP •

NCMC Office
21216 Northwest Fwy, Ste. 470
Cypress, TX 77429
Tel: 281-469-2838
Fax: 281-469-9314

Cypress Skinner Office
13611 Skinner Rd, Ste 145
Cypress, TX 77429
Tel: 281-304-7337
Fax: 281-469-9314

Cypress Springs Office
7626 Fry Road, Ste 500, Cypress,
TX 77433
Tel: 281-469-3305
Fax: 281-469-9314

Katy Office
22762 Westheimer Pkwy., Ste. 560,
Katy, TX 77450
Tel: 281-921-0590
Fax: 281-469-9314

Fulshear Office
11605 S Fry Rd., Ste. 108
Fulshear, TX 77441
Tel: 281-469-4340
Fax: 281-239-2104

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

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

I hereby authorize Steeplechase Pediatric Center to release my child's medical records to:

Name of Medical Practice, Physician, Clinic or Hospital

Address: _____

City, State, Zip _____

Phone Number _____

…for purpose of: ____ transfer of case will be a charge of $25 ____ proof immunizations

____ Insurance review ____ legal matters go through Attorney

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