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• Sandy Nguyen, APRN, FNP-C • Tami Pogue, RN, MS, C-PNP • Kathy LeBeouf, RN, MSN, CPNP •

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