AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name_____

DOB_____

I, _____hereby authorize the release of medical information

TO:

Kids First Pediatrics
7025 N Fry Road, Suite 200
Cypress, TX 77433
832.975.7288 (office) 832.975.7287 (fax)

FROM:

Doctor/Clinic/Hospital: _____

Address: _____

_____

Telephone: _____

Fax: _____

Please release the following:

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

_____ History/Physical

_____ Progress Notes

_____ Discharge Summary

_____ Consultation Reports

_____ Other (specify):_____

_____ Diagnostic Test Reports

_____ Radiology/Images

_____ Lab Results

_____ Pathology Reports

I consent to the release of information related to infection or communicable diseases, and information 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 information

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

_____ 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 that it is revoked in writing.

Signature:_____Date_____

Print Name:_____

Relationship to Patient:_____