138 Old San Antonio Rd, #101, Boerne, Texas 78006 Ph: 830 355 2343 Fax: 830 268 8711

Authorization for Release of Medical Information

Patient Name: _____ DOB: ____/____/_____

I, _____ hereby authorize the release of medical information
(Guardian's name)

TO:
Clinic: Pediatrics of Boerne
Address: 138 Old San Antonio Rd, #101
Boerne, Texas 78006
Ph: 830 355 2343
Fax : 866-981-2606

From:
Doctor/Clinic/Hospital:_____
Address: _____
_____
Ph: _____
Fax: _____

Please release the following:

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

I consent to the release of information related to HIV/AIDS or infection with any other 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 time as it is revoked in writing.

Signature of Parent or Legal Guardian: _____

Date: ____/____/____

Print Name: _____

Relationship to Patient: _____