Geronimo Village Pediatrics

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO **GVP**

_____________________________________ ______________________________________

(Print Patient's Full Name) (Birth Date: m/d/y)

_____________________________________ ______________________________________

(Street Address) (Home Phone Number)

_____________________________________ ______________________________________

(City, State, Zip Code) (Cell Number)

At the request of the individual, I ________________________________, do hereby authorize:

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To release: ___Progress notes___ Pathology Reports___ Other Doctor Notes ___ Lab Reports

___ OB/GYN Notes ____ All Records ____Radiology Reports _____Hospital Notes ___ECG/EEG/Cardio

Other:____

I do / Do Not: Authorize release of information related to AIDS/HIV, or any other communicable diseases, psychiatric care, and/or psychological assessments, along with treatment for alcohol and/or drug abuse.

Information Release To: **Geronimo Village Pediatrics 121 Dennis Drive Seguin, TX 78155**

830-372-8981 **Fax: 830 -372-8984**

Email: GeronimoVillagePediatrics@gmail.com

Purpose of disclosure: ____Referral to Specialist ____Insurance ____ Worker's Comp____ Legal Investigation ____ Disability ____ Personal ____Relocated____

Other (specify):____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization. I understand that I may REVOKE this authorization at any time.

Reason for transferring: ____

I understand I am solely responsible for any fees incurred in copying and / or obtaining these records. _____________(initial)

____ Date:____________________

Patient signature if over 12 years old

____ Date:____________________

Signature of parent/guardian or representative of patient estate

Relationship to patient____