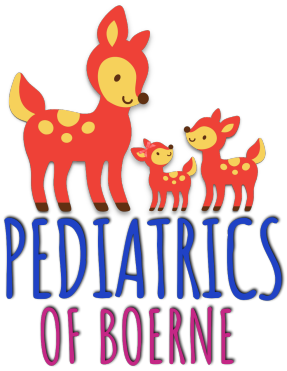

138 Old San Antonio Rd, #101, Boerne, Texas 78006
Ph: 830-35502343 Fax: 830-268-8711

Authorization for Release of Medical Information

Patient Name: _____ DOB: ____/____/_____

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

TO:

Doctor/Clinic/Hospital:__Pediatrics of Boerne__

Address: __138 Old San Antonio Rd,_Ste 101_____

Boerne, Texas 78006

Telephone: _____ Fax : _____

FROM:

Doctor/Clinic/Hospital:_____

Address: _____

_____

Telephone: _____ Fax : _____

Please release the following:

___ **All health information (including growth charts and vaccination records)**

___ History/Physical Exam	___ Discharge Summary
___ Diagnostic Test Reports	___ Lab Results
___ Progress Notes	___ Consultation Reports
___ Radiology/Images	___ Pathology Reports

___Other (specify): _____

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: _____