Medical Records Release Form

By signing this form, I authorize you to release confidential health information about my child, by releasing a copy of my medical records, or a summary of my child's protected health information, to the physician/person/facility/entity listed below.

Patient Name: _____ DOB: _____

I hereby authorize records from:

Facility/Dr Office: _____

Address: _____City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Please select all that may apply:

□ Complete Records □ History & Physical □Progress Notes
□ Care Plans □ Lab Reports □ Radiology Reports
□ Pathology Reports □ Treatment Record □ Operative Reports
□ Hospital Reports □ Medication Record □ Other (please specify) _____

I hereby authorize records to

CareVille Pediatrics P.A
1003 N St Mary's St.
Beeville TX 78102
P: 361-492-5252
F: 361-492-5599

For the purpose of review of medical history by current treating physician.

I understand that authorizing the disclosure of this health information is voluntary. I have the right to refuse to sign this authorization. I do not need to sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules.
I understand that the information in my child's medical record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug use.
I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my child's policy.

I have read the information provided on this release form and do hereby acknowledge that I 'am familiar with and fully understand the terms and conditions of this authorization.

Signature of Patient/Parent/Guardian: _____Date: _____