Authorization to Release and Disclose Patient Information

Nacogdoches Pediatric Extended Care
124 Creek Bend Blvd
Nacogdoches, TX
Phone: 936.569.9812
Fax: 936.569.9820

Patient Name: (Last, First, MI)		
Street Address:		
City:	State:	Zip Code:
Date of Birth	Phone Number:	

1. Information to be release: (check all that apply)
   - History & Physical
   - Office Visits (including physician notes, nurse notes, lab, xray, etc.)
   - Hospital Notes/Procedures
   - Immunization Record
   - Medication Record
   - Other: _____

2. Purpose of this request: _____

- I understand that Nacogdoches Pediatric Extended Care will not condition my treatment on whether I sign this authorization form.
- I understand that this authorization will be in effect until cancelled by me in writing and that cancellation will take effect when the provider receives my notice in writing. A photocopy of this authorization will be treated in the same manner as the original.
- I may revoke or change this authorization at any time in writing to Nacogdoches Pediatric Extended Care, except where a disclosure has already been based upon my prior authorization.
- I understand that it is possible that information used or disclosed with my permission, may be re-disclosed by the recipent and is no longer protected by the HIPPA Privacy Standards.

I have read and understand this information:

Parent/Guardian Name(printed): _____
Date

Parent/Guardian Signature: _____
Date

Witness: _____
Date