Records Release

Medical Records Request

Patient Name: _____**DOB:**_____

By signing this form, I authorize _____to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:**_____ **Date:**_____

Type of Records Requested:

( ) All
( ) Immunization Record
( ) Problem List
( ) Growth Chart
( ) Medication List
( ) Other:_____.
( ) Allergy History
( ) ADHD History

Release my protected health information to the following person(s)/entity:
Through The Years Pediatrics 15316 Huebner Rd #102 San Antonio, TX 78248

Effective Time Period: This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date: Month_____Day_____Year_____.

Right To Revoke: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEICE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

The reason or purpose for this release of information are as follows: Transfer of Care

Patient Signature (or parent, guardian or legal representative):

_____Date:_____