**PEDIATRICS OF SOUTHWEST HOUSTON**
**6700 W Loop S # 300, Bellaire, TX 77401**
**Phone: (713) 988-1334 Fax: (713) 988-6165**

Pediatrics of Southwest Houston

## HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

**Please allow up to 30 days for processing. There is a Transfer of Records Fee of $25 for records picked up in our office and $30 to mail**. The medical records cannot be released until this form is completed and signed by the patient (if at least 18 years old) or parent or legal guardian (if under 18 years old). ***You must complete this form thoroughly.***

## PLEASE PRINT

**Step 1**: Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Address_____
Street City State Zip Code

Mobile Phone #_____ E-mail address: _____

**Step 2**: I hereby authorize Pediatrics of Southwest Houston the use and /or disclosure of protected health information (PHI)

☐ **FROM** ☐ **TO**

Name of Physician/Medical Facility_____

Address: _____
Street City State Zip Code

Phone Number: _____ Fax Number: _____

Date of Service: _____ to _____

**Step 3: Please send the following records:**

☐ Entire Medical Record ☐ Consult Reports ☐ Radiology Reports
☐ Immunization Record ☐ Laboratory Reports ☐ ADHD or School Reports

**Step 4: Purpose for disclosure is at the request of the individual based on the following:**

*(This section must be completed before the records will be released)*

☐ Continuity of Care Other Reason: _____
☐ Transfer of Care _____

**Step 5: CONDITIONS OF AUTHORIZATION**

I have the right to revoke this authorization at any time by writing to the health care provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
I understand that signing this form is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State privacy regulations.
A copy of this authorization has been provided. This authorization is **valid for 90 days** for the release of information as indicated by date of signature below.

_____ _____
*Patient/Guardian Signature & Date* *If not the patient, name and authority to sign on their behalf & Date*

**Please choose one of the following:** ☐ I plan to pick up my records. **OR** ☐ Please send my records.