PEDIATRICS OF SOUTHWEST HOUSTON 6700 W Loop S # 300, Bellaire, TX 77401

Phone: (713) 988-1334 Fax: (713) 988-6165



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). <u>You must complete this form thoroughly.</u>

Step 1: Patient Name:	Stop 1. Deticat Name			Data of Distlet		
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 (PIFROM TO Name of Physician/Medical Facility	Patient Name:			Date of Birth:		
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FROM TO Name of Physician/Medical Facility	Mobile Phone #	E-n	nail address:			
Name of Physician/Medical Facility	Step 2: I hereby authorize Pediatrics of	Southwest Houston the	e use and /or dis	closure of protected hea	lth information (PHI)	
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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.	-		If not the patie	ent, name and authority to sign	on their behalf & Date	