Children's Specialty Care Clinic of Northwest Houston, P.A.

Send records to: P.O. Box 1176, Waller, TX 77484

Phone: 936-931-3448 Fax: 936-931-3704

Release Of Information

Patient Name:_____ Date of Birth:_____

Address:_____ Phone:_____

I hereby authorize the physicians and representatives of

Children's Specialty Care Clinic of Northwest Houston, P.A.

_____To obtain confidential information from _____To release confidential information to

Name:_____

Address:_____

Phone:_____Fax:_____

For the purpose of: _____continuation of care _____Legal attorney _____other_____

The following information should be released/obtained:

___Entire Records _____Diagnostic Test Results _____Hospital Records

_____Immunization Records _____Other:_____

I understand that I may revoke this authorization in writing at any time prior to the release of the information specified above. I hold **Children's Specialty Care Clinic of Northwest Houston** and their representatives from liability resulting in the release/obtaining of the information. This authorization expires 90 days from sign date.

Pursuant to the State and Federal Law, you are hereby advised that the information that you authorized for release may include: any and all test results, diagnosis and/or treatment for HIV(AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol abuse.

Signature_____ **Relationship**_____ **Date**_____