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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ DOB: _____

Parents Name: _____ Daytime Phone: _____

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

From: _____	To: _____
_____	_____
_____	_____
Ph # _____	Ph# _____
Fax # _____	Fax # _____
(Previous Doctor)	(New Doctor)

Limitation on the information you may release subject to this Release Form are as follows:

_____
_____
_____

The reasons or purposes for this release of information are as follows:

_____
_____
_____

Parent Signature (Guardian or legal representative)

_____ Date: _____

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.