STEP PEDIATRICS

4800 West Panther Creek Ste 100 The Woodlands TX 77381
281-364-8600 **Fax 281-298-2005**

Authorization for : ☐ Disclosure ☐ Inspection ☐ Amendment Of Protected Health Information

PATIENT NAME **DATE OF BIRTH** **SSN**

ADDRESS **TELEPHONE #** **( )**

I hereby authorize_____
Print Name of Facility Holding Health Information

To release information from the medical records of _____
Patient Name

To:_____
Print Name/Address of person/organization to which disclosure is to be made

Fax #_____ **Phone #**_____

For treatment dates:_____
SPECIFY DATES---THIS LINE MUST BE COMPLETED

For the following purpose: ☐ Medical Care ☐ Legal ☐ Insurance ☐ Other (detail)
_____

Select Portions

- ☐ Abstract/Pertinent Information
- ☐ Lab
- ☐ Emergency Room
- ☐ Imaging/Radiology
- ☐ Nursing Notes
- ☐ H & P
- ☐ Cardiac Studies
- ☐ MD Progress Notes
- ☐ MD Orders
- ☐ Face Sheet
- ☐ Operative Procedure/Report

- ☐ Entire Record EXCLUDING HIV testing & chemical dependency
- ☐ Entire Record INCLUDING HIV testing & chemical dependency
- ☐ Entire Record INCLUDING HIV testing only
- ☐ Entire Record INCLUDING chemical dependency only

This authorization is valid until the 180th day after the date it is signed unless it provides otherwise, not to exceed 24 months, or unless it is revoked, and covers only treatment(s) for the dates specified above.

I, the undersigned, have read the above and authorize the staff of STEP PEDIATRICS to receive the above information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it.
***When requesting release of information from STEP PEDIATRICS to another facility/person*, I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless STEP PEDIATRICS from all liability and damages resulting from the lawful release of my protected health information. Fees/charges will comply with all laws and regulations applicable to release of Protected Health Information. Payment is due at time of release.**

_____ _____ _____
Date **Signature of Patient/Parent/Guardian/Conservator** **Relationship to Patient**