Heights Pediatrics
100 W Central Texas Expressway Suite 110
Harker Heights, TX 76548
Phone 254-213-4052 Fax 254-213-4083

Patient Name	Birth Date	Social Security Number
Address		Telephone Number

I hereby authorize (Physician/Facility Name)____
To release information (by fax or mail) from the medical record of the above mentioned patient to:
Physician/Facility Name & address or fax#:

____

For the following purpose or treatment:

- ☐ H & P
- ☐ Immunization Record
- ☐ Current Information
- ☐ Progress Notes
- ☐ Consultation Reports
- ☐ Other
- ☐ Labs
- ☐ All Records-Changing Primary Care Physician

Type of Access Requested: ☐ Copies of Records ☐ Inspection of Records

This authorization expires 90 days from the date signed below and covers only treatment for the dates or diagnosis specified above.

__________ (Initials) I acknowledge and consent to such that the released information may contain but is not limited to the following information: alcohol and drug results, sexually transmitted diseases and HIV results.

I, the undersigned, have read the above and authorize the staff of KPCC to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I understand the re-disclosure of this information to a party other than the designated above is forbidden without additional authorization on my part. This facility is released and discharged of any liability and the undersigned will hold the facility harmless, for complying with this "Authorization for Release of Medical Information." Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for (1) conducting research-related treatment, (2) obtaining information in connection with the eligibility for enrollment in a health plan, (3) determining an entity's obligation to pay a claim, or (4) creating health information to provide to a third party.

Date:

Patient Parent or Guardian Signature:

Witness Signature:

For Office Use Only

Date Received:	Processed by:
Date Processed:	Please circle: By fax By Mail Pick Up