



GENTLE PEDIATRICS

22001 Southwest Freeway, suite 115, Richmond, TX
77469 Ph 832-222-5437
Fax 832-222-5438

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME _____ Date of birth _____

Please release the following records of above mentioned patient to GENTLE PEDIATRICS.

- 1. All medical records
- 2. Lab reports
- 3. Other (specify) _____

I authorize the release of protected health information about the child mentioned above from

Dr./Hospital _____ phone # _____ fax # _____

to **GENTLE PEDIATRICS** by fax or postal mail. I understand this authorization expires 180 days from the date of my signature unless I specify otherwise.

NAME OF PARENT/LEGAL GUARDIAN _____

RELATIONSHIP TO CHILD _____

SIGNATURE _____ DATE _____