6909 Brisbane Court Suite 100
Sugarland, Tx 77479
Phone: 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 _______________________