

AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

I hereby authorize:

AUSTIN CHILDREN'S CLINIC, PA
Mary Petropoulos, MD
11673 Jollyville Road, Suite 104
Austin, TX. 78759
512-338-5130
512-338-5112 Fax

To release copies of the medical records listed below to:

Physician, Facility or Person

Mailing Address

City, State, Zip Code

Phone Number/Fax Number

This release pertains to:

_____ Patient Name	_____ DOB
_____ Patient Name	_____ DOB
_____ Current Address	
_____ Current Phone Number	

This authorization applies to:

_____ All Records
_____ Immunizations Only
_____ X-Ray and Lab Only

For the purpose of:

_____ Medical Care
_____ Change of Physician due to insurance change
_____ Other (state below)

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. **Initial** _____ **Date** _____

This authorization is valid for 90 days from the date of signature by the participant.

Prohibition of Redisclosure: Federal rules prohibit any further disclosure of this information unless disclosure is expressly permitted by written consent of the person to whom it pertains.

Signature of Parent or Legal Guardian

Date

The Patient, Parent or Guardian may revoke this authorization in writing at any time.

Relationship to Patient

THERE IS A \$15.00 CHARGE FOR RELEASE OF ANY MEDICAL RECORDS.