Authorization for Release of Healthcare Information

I hereby authorize the transfer /receipt of the following healthcare information.

FROM: _____Physician's Name

_ ----------Address

_____City, State, Zip

_____ Telephone

----------Fax

TO: Pearsall Pediatrics
Gurney F. Pearsall, M.D.
3003 South Loop West Suite 410
Houston, TX 77054
713-790-9265 Office
713-790-1006 Fax

Information Needed:

_**Complete Record**

_ Consultation Reports
Initial Intake
_ Laboratory Reports
_Psychiatric Assessment
Treatment Plan

_ Discharge Summary
Insurance/Referral Related
_ Operative Reports
_Psychological Reports
Insurance/Referral Related

_ History & Physical Exam
Immunization Record
_Progress Notes
_ Psychosocial History
_X-Ray Report

Reason for information: _ Transferring Physician _ Other (Specify): _____ __

I understand that specific information to be released may include, but is not limited to history, diagnosis and/or treatment of drug or alcohol abuse, mental/psychiatric related illness or communicable disease, including human immunodeficiency virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand this consent can be revoked at any time except to the extant that disclosure made in good faith has already occurred in reliance on this consent. The revocation must be in writing and delivered to the Pearsall Pediatrics Medical Records Department. It is further understood that the information released is for specific purpose sated above and may not be provided in whole or in part to any other agency, organization or person. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ _____
Child's Name Date of Birth Child's Name Date of Birth

_____ _____
Child's Name Date of Birth Child's Name Date of Birth

*'"**THIS AUTHORIZATION EXPIRES 180 DAYS AFTER DATE OF SIGNATURE****

_____ _____
Parent's Signature** (if **child is under 18 years old) ***Date Signed***

There is a $10.00 fee for a copy of your child's immunization record.
There is a $45.00 fee/or a complete copy of your child's medical records.