Mid Valley Pediatrics and Allergy
1010 S Airport Dr.
Weslaco, TX 78596
Tel: 956-969-2609 Fax: 956-973-0413

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

PATIENT NAME ______________________________ MEDICAL RECORD # ______________________

DATE OF BIRTH: ______/______/______ SOCIAL SECURITY #: ______________________ (OPTIONAL)

I authorize the following individual or organization to disclose the above named individual's health information:

Mid Valley Pediatrics and All 1010 S Airport Dr. Weslaco, TX 78596 TEL (956)969-2609 FAX (956) 973-0413

This information may be disclosed TO and used by the following individual or organization:
NAME/ORGANIZATION: ______________________ TELEPHONE #: ______________ FAX: ______________
ADDRESS: ____
FOR THE PURPOSE OF: ____

Please release the following: ________ **ENTIRE RECORD** ________ **TRANSFER OF ALL RECORDS TO ANOTHER PROVIDER**

OR
- ____ **Problem List**
- ____ **Progress Notes**
- ____ **History/Physical Exam**
- ____ **Medication List**
- ____ **Immunization Record**
- ____ **List of Allergies**
- ____ **X-Ray/Imaging Reports from (date) ___/___/___ to (date) ___/___/___**
- ____ **X-Ray Films**
- ____ **Laboratory Results from (date) ___/___/___ to (date) ___/___/___**
- ____ **EKG Reports**
- ____ **Genetic Testing Information**
- ____ **Other Diagnostic Reports (specify)** ______________________
- ____ **Other (specify)** ______________________

I understand that the information in my health record may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

______ **YES, I CONSENT THE RELEASE OF THIS INFORMATION** _____ **NO, I DO NOT CONSENT THE RELEASE OF THIS INFORMATION**

I understand that the information released is for the specific purpose stated above. Any other use of this information without written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following **DATE:** ______/______/______.

I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 162-524. I understand that any disclosure of information carries it with the potential of an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact **MID VALLEY PEDIATRICS AND ALLERGY** at the address stated above.

______________________________ ______/______/______
Signature of Patient or Legal Representative **Date**

______________________________ ______________________
Relationship to Patient (If Legal Representative) **Witness**

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record contains reports, test results, and notes that only a Physician can interpret. I understand and have been advised that I should contact my Physician regarding entries made in my medical record to prevent my misunderstanding of the information in my medical record as a result of not consulting not hold ______________________ liable for any misinterpretation of the information in my medical record as a result of not consulting my Physician for the correct interpretation.

______________________________ ______/______/______
Signature of Patient or Legal Representative **Date**

______________________________ ______________________
Relationship to Patient (If Legal Representative) **Witness**

(FOR STAFF USE ONLY) Completed by: ______________________ **Date:** _____/_____/_____