INWOOD VILLAGE PEDIATRICS

5470 W. Lovers Lane, Suite 330
Dallas, Texas 75209
Phone: (214) 956-7337
Fax: (469) 364-8724

AUTHORIZATION FOR OBTAINING OF INFORMATION

I hereby authorize Inwood Village Pediatrics to initiate the disclosure and transfer of my child's individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV') and Acquired Immune Deficiency Syndrome ("AIDS'), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization.

I understand that my child's records may be subject to disclosure by the recipient, and may no longer be protected by federal privacy regulations.

Patient Name _____ **Date of Birth** _____

Patient Name _____ **Date of Birth** _____

Patient Name _____ **Date of Birth** _____

From:

Doctor/Clinic Name: _____

Address: _____

Phone #: (____) _____ **Fax #: (____)** _____

To:

Inwood Village Pediatrics ❍ Dr. Browning ❍ Dr. Deuber ❍Dr. Hamner ❍Dr. Hubbard ❍Dr. Khouri ❍Dr. Linderman
5470 W. Lovers Lane, Suite 330
Dallas, TX 75209
Phone: 214-956-7337 Fax: 469-364-8724

Check all protected health information that may be released:

❍ All Medical Records ❍ Office Visit Notes ❍ Immunization Record
❍ Lab Reports ❍ Growth Charts

Dates range:

From: _____
To: _____

Purpose of disclosure:

❍Medical Care ❍ Attorney ❍ Parental Retention
❍ Insurance ❍ Other_____

I understand that this authorization will expire by law 180 days from the date of this authorization.

_____ _____
Signature of Parent or Legal Guardian **Date**

(OR)

_____ _____
Printed Name of Parent or Legal Guardian **Legal Authority (attach supporting document)**

_____ _____
Relationship to Patient/Patients **Inwood Village Pediatrics Representative**