

**GRAND PARKWAY PEDIATRICS**  
**5610 W. RIVER PARK DRIVE, SUITE A, SUGAR LAND, TX 77479**  
**281-494-8687**  
**fax 281-494-5201**

Authorization for release of medical information or medical record

I hereby authorize _____ (Doctor's Name, Address, Phone Number, Fax Number)			
To release information from the medical records of _____ (Child's Name)			
(Date of Birth)	(Telephone Number)	(Cell Number)	
(Address)	(City)	(State)	(Zip)
To: <u>Grand Parkway Pediatrics, 5610 W. River Park Drive, Suite A, Sugar Land, TX 77479</u>			
For treatment dates: _____			
For the following purpose:    Medical Care            Legal            Insurance            Other (detail below)			
Complete Record: <b>INCLUDING</b> or <b>EXCLUDING HIV TESTING AND/OR RESULTS</b> (circle one)			
Immunization Record			
Lab			
Imaging/Radiology			
Progress Notes			
Correspondence			

This authorization is valid until the 180<sup>th</sup> day after the date it is signed unless it provides otherwise, not to exceed 24 months, or unless it is revoked, and covers only treatment(s) for the dates specified above.

This authorization is given freely with the understanding that:

- a) I may revoke this authorization at any time except where information has already been released.
- b) I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected.
- c) I hereby release and hold harmless the above named facility from all liability and damages resulting from a lawful release of my Protected Health Information.
- d) A copy of your child's immunization is provided at no charge. There is a charge of \$28 for copies of complete medical records.**

Date	Signature of Patient/Parent/Conservator/Guardian	Relationship to Patient
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