

**'Specially For Children  
Authorization for Release of Health Information**

I hereby authorize 'Specially For Children' to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immunodeficiency Syndrome ("AIDS"), mental illness (except 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 further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal and state privacy regulations.

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<b>Print Patient Name</b>	<b>Date of Birth</b>	<b>Social Security Number</b>
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<b>Date(s) of Service for Records Being Requested (Be Specific)</b>	<b>Name of Physician, from whom Records are being requested</b>
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Description of Health Information to be released:

<input type="checkbox"/> Complete Medical Record	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Consultation	<input type="checkbox"/> Operative Report	<input type="checkbox"/> Pathology Report
<input type="checkbox"/> Lab Report	<input type="checkbox"/> X-ray Report	<input type="checkbox"/> EKG
<input type="checkbox"/> Emergency Record	<input type="checkbox"/> Clinic Notes	<input type="checkbox"/> Other: (specify) _____

Purpose of Disclosure:

<input type="checkbox"/> Attorney/Legal	<input type="checkbox"/> Continued Patient Care
<input type="checkbox"/> Commercial Insurance	<input type="checkbox"/> Personal Use
<input type="checkbox"/> Other: (specify) _____	

**Release my protected health information (referenced above) to the following physician/person/facility/entity:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I understand that this authorization will expire within one year from the date of this authorization. \_\_\_\_\_  
Initial/Date

I understand that I may revoke this authorization by requesting a written revocation of authorization that can be obtained by calling/writing to the phone number/address listed at the bottom of this page. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

I also understand that 'Specially for Children' will provide this information 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

**Signature for Authorization:**

\_\_\_\_\_  
Patient or Patient Representative Name

\_\_\_\_\_  
Signature of Patient or Patient Representative Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Or, Legal Authority (attach supporting documentation)