Forest Pediatrics

Murray B. Fershtman, M.D.

Authorization for Disclosure of Confidential Information

Patient Full Name: _____ DOB: ____/____/____

Patient Full Name: _____ DOB: ____/____/____

Patient Full Name: _____ DOB: ____/____/____

I hereby authorize my child/children's medical records to be released from:

_____

Name of Medical Practice, Physician, Clinic, or Hospital

Address: _____

City, State, Zip: _____

Ph: _____ Fax: _____

To be released to:

☐ **Forest Pediatrics**
3115 College Park Dr. Suite 104
Conroe, TX 77384
Phone: (936) 321-5030
Fax: (936) 271-5033

☐ **Name:** _____
Address: _____
City, State, Zip: _____
Phone: _____ **Fax:** _____

For the purpose of:

☐ Continuing or transfer of medical care
☐ Legal Matters
☐ Proof of Immunization
☐ Insurance Review or Underwriting

Release information concerning the following dates: **From** _____ **to** _____, and to include:

☐ Complete Medical Record
☐ Lab Reports Only
☐ Other: _____
☐ Immunizations Only
☐ Progress Notes Only

Also, I ☐ **DO** or ☐ **DO NOT** (*check one & initial* _____) consent to release of information pertaining to psychiatric or psychological testing or treatment, biofeedback training, alcohol and/or drug abuse diagnosis/treatment, or HIV (AIDS) testing.

I, the parent/legal guardian, agree that a photocopy or facsimile (fax) of this authorization may be considered valid, this authorization shall be valid for 120 days from the date of signature, and that this authorization can be revoked in writing at any time prior to the expiration date.

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. I hereby release and hold harmless the above named medical practices, physician, or facility from all liability and damage resulting from the lawful release of my protected health information.

_____ _____

Signature of Parent/Legal Guardian *Date*