HUEBNER PEDIATRICS

Adelnery Gonzalez, M.D. Michelle Storandt, M.D.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION

PATIENT'S NAME:_____ **DOB:**_____

I Authorize:

_____
_____
_____
_____

Release To:
Huebner Pediatrics PA
15714 Huebner Rd. #3
San Antonio, TX 78248
Office: (210)447-3000
Fax: (210) 447-3001

Information to be disclosed:

- O Entire Medical Records
- O Immunization Records
- O Lab Reports
- O Hospital Admission Summary
- O Hospital Discharge Summary
- O Treatment from _____ to _____
- O Other:_____

I authorize the use and disclosure of mine and my child's identifiable health information as described above, including verbal and written exchanges about the information unless I indicated otherwise. I understand that this authorization is voluntary. I understand that if the person or organization I authorize to receive the information is not a health plan or healthcare provider, the released of information may no longer be protected by federal privacy regulations and could be re-disclosed. I understand that I may revoke this authorization in writing at any time, except to the extend action has already been taken in reliance on it. I understand that my health care and payment of my healthcare will not be affected if I do not sign this form.

A photocopy or fax of this authorization will be treated in the same manner as the original.

_____ _____
Signature of Patient/Legal Guardian Date

_____ _____
Relationship to Patient Witness

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