AUTHORIZATION TO RELEASE/DISCUSS *OUTGOING* HEALTHCARE INFORMATION

Patient Name: ____________________________ **DOB:** ______________ **Phone:** ____________________

I, _______________________________, residing at ____
(name) (address)

authorize release of information from:

Beansprout Pediatrics
1008 RR 620 S, Suite 101
Austin, TX 78734

512-610-7030
Fax 512-610-7034

Information to be released/discussed to: ____
Address: ____
____
Phone: __________________________ Fax: ____________________________________

PURPOSE OF RELEASE (please check one):
Changing Physicians (reason for transfer) ___________________ Legal _____
Other ____________________

Although it will be requested, I understand confidentiality at the receiving end cannot be guaranteed.

TYPE OF INFORMATION TO BE RELEASED:

General Medical Records - excluding protected material
Specific Information Only: ___________________________________

Other Practitioners Records
Other: ____

PROTECTED OR SENSITIVE INFORMATION:

I understand that certain information cannot be released without specific authorization as required by law.
By initialing, I authorize release of the following protected information:
____Mental Health Information:
____Drug Abuse/Alcoholism Information
____AIDS/HIV Test results- including high risk behavior
____Other sexual information such as dysfunction or related diseases

I UNDERSTAND THAT:
**I can revoke my consent at any time prior to the release of records by delivering a written, signed and dated notice of my wish to Beansprout Pediatrics.
**I can refuse to disclose some or all of my records, but if I do so, it could result in any improper diagnosis or treatment, denial
of coverage of a claim for health benefits or other adverse consequences. Incomplete records may be labeled to inform the receiving of their status.
**I can edit and/or obtain a copy of this release upon request.

____ ______________________
Signature of Parent/Guardian or Authorized Representative Date