



AUTHORIZATION TO RELEASE/DISCUSS *INCOMING* HEALTHCARE INFORMATION

Patient Name: _____ **DOB:** _____ **Phone:** _____

I, _____, residing at _____
(name) (address)

authorize release of information from: _____

Address: _____

Information to be released/discussed to:

Beansprout Pediatric, PLLC
1008 RR 620 S, Suite 101
Austin, TX 78734

512-610-7030
Fax 512-610-7034

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