



**Hill Country
Pediatrics, P.A.**

Dear Parents/Guardians,

We will provide one copy of a summary of your Child's visits to include immunization history, growth charts, and problem list free of charge. A set of records to include all of the above plus progress notes, office visit notes, labs, and consult letters can be provided to you as a parent for a minimum charge of \$ 25 for the first 20 pages, and \$.50 per page thereafter, pursuant to Texas Medical Board Rule Chapter 165.2, section e, subsection 1. The ENTIRE medical record can be forwarded to your new physician at **NO CHARGE** to you.

I hereby authorize the release of information from the medical record of:

Patient Name: _____ Date of Birth: _____

Daytime Phone #: _____

Information Released To:

From:

Please Release the Following:

- | | |
|--|---|
| <input type="checkbox"/> Problem List | <input type="checkbox"/> X-Ray Reports |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> X-Ray Films |
| <input type="checkbox"/> History/Physical Exam | <input type="checkbox"/> EKG Reports |
| <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Other Diagnostic Reports (Specify) _____ |
| <input type="checkbox"/> Immunizations | <input type="checkbox"/> Other (Specify) _____ |

Including information (if applicable) pertaining to:

Mental Health Drug/Alcohol HIV/AIDS Communicable Treatment

Purpose of Need for Disclosure:

- | | |
|---|--|
| <input type="checkbox"/> Continued Patient Care | <input type="checkbox"/> Personal Use |
| <input type="checkbox"/> Attorney/Legal | <input type="checkbox"/> Insurance Claim/Application |
| <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Other (Specify) |

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless otherwise specified.

Signature of Patient or Legal Representative

Date

Relationship to Patient

Witness