AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Relationship to patient (circle one): **Self** **Parent** **Guardian**

Patient's First & Last Name: _____ **Date of Birth**: ____/___/_____

I hereby authorize the release of medical records from:

Name of Medical Practice, Physician, Clinic or Hospital:_____

Address: _____

City, State, Zip: _____

Phone Number: _____ Fax Number: _____

…. to be released to:

Brio Pediatrics
Nancy Elawabdeh, MD
23127 IH 10 W Ste. 101
San Antonio, Texas 78257
Phone: 210-922-1850 Fax: 210-922-1899

…for purpose of:

___ For continue of care
___ Insurance review
____ Proof immunizations.
____ Legal matters

____ Complete Record
____ Records of care from the following dates _____ to _____
____ Other, please specify: _____

Also, I __Do or __Do NOT consent to release of information relating to psychiatric or psychological testing or treatment, biofeedback training, alcohol and/or drug abuse diagnosis/treatment or HIV(AIDS) testing.

I, the parent/guardian, agree that a 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.

Printed name of Guardian:_____Signature:_____ Date:_____