AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION TO KELLIWOOD FAMILY PRACTICE

Patient Name:_____Date of Birth:_____

Address:_____Telephone #:_____

City State Zip:_____

I hereby authorize:

Name:_____Address:_____

City:_____State:_____Zip:_____

to disclose information from my/my minor child's medical record to:

Kelliwood Family Practice
701 S. Fry Road, Suite 103
Katy, TX 77450
281-398-4222
Fax 281-398-4001 (Less than 10 pages only)

This information is needed for the following reason:

_____

The specific information I wish to have released is:

_____**LAB AND DIAGNOSTIC REPORTS ONLY** _____**IMMUNIZATION RECORDS**

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for one year from the date it is signed.

_____ _____
Signature (Parent or Legal Guardian if minor) Date

_____ _____
Witness Expiration date

This medical record may contain information about drug abuse, alcoholism, alcohol abuse, venereal disease, abortion, or mental health treatment. Separate consent must be given before this information can be released.
_____I DO consent _____I DO NOT consent to have this information disclosed.

_____ _____
Signature (Parent or Legal Guardian if minor) Date

This medical record may contain information concerning HIV testing and/or AIDS diagnosis treatment. Separate consent must be given before this information can be released.
_____I DO consent _____I DO NOT consent to have this information disclosed.

_____ _____
Signature (Parent or Legal Guardian if minor) Date