



College Park Medical Plaza 3115 College Park Drive,
Suite 104 Conroe, TX 77384
Phone- 936-321-5030 or toll free 877-271-5030
Fax- 936-271-5033

HIPAA Authorization for Release of Information Form

I hereby authorize use or disclosure of protected health information about me as described below.

The following specific person or class of persons or facility is authorized to make the following requested use or disclosure: (Whom we need records from.)

The following person or class of persons may receive disclosure of protected health information about me:

MAIL RECORDS TO: **Forest Pediatrics**
 3115 College Park Drive, Suite 104
 Conroe, TX 77384
 936-321-5030

RECORDS ON (PATIENT NAME): _____
DATE OF BIRTH: _____

Specific description of information to be released: ___ ALL RECORDS INCLUDING VACCINATION RECORDS or ___ SPECIFIC DATES OF SERVICE ONLY (list dates) _____

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and then would no longer be protected by federal privacy regulations.

I may revoke or withdraw this authorization by notifying Forest Pediatrics in writing of my desire to revoke it. However, I understand that any action already taken in advance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

This authorization will expire on _____, or one year after the date of said authorization.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

Signature of Individual or Guardian Date of signature Date of Birth

Guardian's relationship to minor

A copy of this completed, signed, and dated form must be given to the individual or person signing on the individual's behalf.