AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

Please release medical records to: **First Steps Pediatrics, PLLC**
9910 W Loop 1604 N #124
San Antonio, TX 78254
(210) 692-0358

Please release medical records from: ____
Physician's Name or Name of Practice where records are coming from

____
Physician's Address with suite number City State Zip Code

I hereby request and authorize the physician or practice listed above, to release a copy, summary, or narrative of my medical records, as indicated by the checkmark(s) below, or otherwise confidential information.

- ❑ Complete record
- ❑ Records of care from the following dates: _____________to_____________
- ❑ Records concerning the following conditions:____
- ❑ Other, please specify:____

Patient Name: ____ Date of Birth: ___/___/____
Please Print

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records:

Initials: __________Date: ___/___/___

The reason or purpose for this release of information is as follows:
- ❑ Insurance
- ❑ Moving
- ❑ Other:____

I understand that this is a required consent and that I must voluntarily and knowingly sign this authorization before any medical records can be requested.

____ ____/____/____
Parent's Signature Date

____
Print Name

Notice: Texas State Law requires that within 15 days upon receipt of medical records request, a physician shall furnish copies, summary, or narrative of the requested records, including records received from another physician or healthcare provider involved in the care or treatment of a patient.