Sugar Land Pediatric Clinic
AUTHORIZATION FOR RELEASE OF MEDCIAL INFORMATION

_____

Printed Name   **Date of Birth**

I, _____, hereby authorize the use and/or disclosure of protected
(Parent/Guardian)   health information (PHI)

To: Telfair Pediatrics P.A. DBA Sugar Land Pediatric Clinic
     13440 University Blvd. Suite 150, Sugar Land, TX 77479 Phone: 281-207-9191 Fax: 281-207-9533

From: _____

       _____

Date of service _____ to _____

(   ) Entire Medical Record   (   ) Consult Reports   (   ) Radiology Reports

(   ) Immunization Record   (   ) Laboratory Reports   (   ) ADHD or School Reports

I understand that the information in my record may include information relating to the sexually transmitted diseases which may include, but are not limited to diseases such as hepatitis, syphilis, gonorrhea, the human immunodeficiency virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS). It may also include information about behavior or mental health services and treatment for alcohol and drug abuse.

This information will be used for:

(   ) Continuing Care   (   ) Insurance   (   ) Second Opinion

(   ) Consultation   (   ) Legal   (   ) Personal

I understand that I can revoke or terminate this authorization by submitting a written revocation to the address listed below except to the extent that disclosure made in the good faith has already occurred in reliance on this consent. Without prior revocation, this **authorization will automatically expire six months** from this date. If I have questions about disclosure of my health information, I can contact Sugar Pediatric Clinic at 281-207-9191. If neither federal nor Texas privacy law apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Texas privacy law.

_____   _____
Signature of Parent or Legal Representative   **Printed Name**

_____   _____
Relationship to Patient (If Legal Representative)   **Date**

_____   _____

**Telfair Pediatrics P.A. DBA Sugar Land Pediatric Clinic Staff Witness Signature   Date Requested
Aliya S. Ahmed, M.D. / Nina S. Singhal DO**