UNIVERSITY PEDIATRIC ASSOCIATION
Authorization for Release of Information
(Request by Patient or Patient's Representative)

I hereby authorize University Pediatric Association to release my individually identifiable health information as described below, including but not limited to information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any such related information. I understand that if the recipient authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal and state privacy regulations.

Patient Name: _____Date of Birth: _____

Address: _____City: _____ State: _____Zip: _____

Telephone No.: (_____)_____Treatment Date: _____

This information is to be released:

TO: _____ FROM: _____

_____ _____

_____ _____

City State Zip City State Zip

PLEASE CHECK INFORMATION REQUIRED TO BE RELEASED

____Progress Notes	____Nurse's Notes	____Discharge Summary
____Physician's Orders	____Consultation reports	____Admission Records
____Emergency Room	____Radiology reports	____Laboratory reports
____Billing records	____Immunization Records	____All Records

PURPOSE OF DISCLOSURE

____Attorney/Legal	____Continued Patient Care
____Commercial Insurance	____Personal Use
____Hospital	____Other (Specify)
	_____

I understand that UPA will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners. It is further understood that the information released is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization, or person. This consent will expire 180 days after date of signature.

_____ _____
Parent or Guardian Date

_____
Relationship to Patient

Office Use Only

Date Records released: _____ Relationship to patient: _____

Amount charged for records: _____ Employee initials: _____