



**Willow Bend Pediatrics**  
 Michael J. Frank, M.D., F.A.A.P.  
 Kimberly F. Mehendale, M.D., F.A.A.P.  
 Susan J. Sickler, M.D., F.A.A.P.  
 Shobha Michaels, M.D., F.A.A.P.  
 Janet S. Le, M.D.

**Authorization for Disclosure of Confidential Information**

I hereby authorize the release of information from the medical record of:

Patient Name \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

**I authorize Willow Bend Pediatrics to release medical information to:**

Name of person/facility \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_

**This information is necessary for the following purpose:**

- Change of Physician     Personal Use     Continued Patient Care     Legal     Insurance  
 Other (Specify): \_\_\_\_\_

**Check all that may be released:**

- Complete medical record - A fee of \$25 for the 1<sup>st</sup> 20 pages, which includes postage charges. There will not be a charge for medical records released to a physician. Please enclose a check payable to Willow Bend Pediatrics. Additional pages are 15 cents per page. This fee is in compliance with Texas State Board of Medical Examiners rules regarding fees for medical records. This includes the problem list, shot record, growth chart, and well visits. Please mark other information needed.
- Immunization     Lab Reports/X-ray     Progress Notes  
 Problem List     Other (please specify) \_\_\_\_\_

You will be notified of any fee for partial records prior to the record being duplicated. Please note: Due to patient confidentiality law, medical records cannot be sent by fax except in cases of medical emergency.

This authorization covers patient care given from \_\_\_\_\_ to \_\_\_\_\_

**Informed Consent for Release of Confidential Information:**

**I understand that:**

I may revoke this consent in writing at any time except to the extent action has already been taken.  
 This consent will expire 180 days after the date of my signature unless otherwise specified.  
 I understand that there is a fee for copy services rendered and payment of the fee is due prior to my records release.  
 I understand that this information may include HIV/AIDS, Mental Health & Chemical Dependency diagnosis, treatment, & test results  
 I understand that the information released is for the specific purpose stated above.  
 I understand that my medical records may contain reports that only a physician can interpret.  
 I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries.  
 I will not hold Willow Bend Pediatrics liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.  
 I understand that within fifteen (15) business days of receipt of payment, my records will be available.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to the patient: \_\_\_\_\_