Practical Approach
Pediatrics and Pediatric Dentistry

Authorization for Release of Medical/Dental Information
Please Mail if more than 20 pages DO NOT FAX
Release Expires 1 year from date below

Patient Full Name: _____ **DOB:** __ __/__ __/_____ **PH #:**_____

Patient Address:_____

This will authorize:

Clinic/Dr: _____

Address:_____

City, State, Zip: _____

Phone _____

Fax_____

To Release to:

Practical Approach Pediatrics and Pediatric Dentistry
9480 Huebner Road
Suite 400
San Antonio, TX 78240
Phone: 210-697-3900 **Fax:** 210-697-3904

GENERAL INFORMATION REQUESTED

Medical Information Requested:

- ☐ Complete medical records
- ☐ Lab reports
- ☐ Progress notes, including medication list
- ☐ Immunizations
- ☐ Complete dental records
- ☐ Other _____

Reason for Release:

- ☐ To update my regular doctor (provider)
- ☐ I want/need a second opinion
- ☐ I am changing doctor (provider)
- ☐ My insurance changed
- ☐ I am moving (New Address)
- ☐ Other _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to (Note, you must mark yes or no):

Yes	No	
☐	☐	Substance Abuse (alcohol/drug abuse)
☐	☐	Mental Health/Depression (includes psychological testing)
☐	☐	HIV-Related Information (AIDS related testing)

This consent may be revoked at any time by notifying the above named provider of information.
Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosed information may be reviewed by contacting the provider of information.

RESTRICTIONS:
The authorization is being given with the understanding that the receiver may not further use or disclose the medical information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.

_____ _____
Printed name of patient/authorized representative Relationship to patient

_____ _____
Signature Witness
Date: __ __/__ __/____ Date: __ __/__ __/_____

Faxed: