Authorization for Release of Medical Information

Patient Name: ____ DOB: _____/_____/_____

I, ___________________________________, hereby authorize the release of medical information

TO: Dr. Melissa Handley at Bright Beginnings Pediatrics

Address: 2001 Tulane Drive, Lufkin, TX 75901

Phone: (936) 404-4602 Fax: (936) 262-6504

FROM: Doctor/Clinic/Hospital: ____

Address: ____

____

Phone: ____________________________ Fax: _________________________

PLEASE RELEASE THE FOLLOWING:

____ All health information (including growth charts and vaccination records)

____ Health information ONLY related to: ______________________________________

____ Health information from __________________ to __________________

____ Other: ____

PURPOSE OF DISCLOSURE:

____ Treatment/Continuing Medical Care

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

Signature of Parent or Legal Guardian: _______________________________ Date: ____/____/____

Print Name: _________________________________ Relationship to Patient: ________________

*** If records contain more than 50 pages, please mail. ***