Northwoods Pediatric Center, P.A.
25214 Borough Park Drive
Spring, TX 77380
Ph 281-296-7770
Fx 281-296-9777

Authorization to Release Medical Records
(Please Print)

Patient Name:_____

Date Of Birth:_____

Phone Number:_____
I, undersigned, consent to the release of medical information (records)

TO / FROM:	**TO / FROM (please include phone & fax)**
Northwoods Pediatric Center, P.A.	_____
25214 Borough Park Drive	_____
Spring, TX 77380	_____

Records to be released: (choose one)

All Records or Other:_____

Purpose of disclosure:_____

This is authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing.
4. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this authorization.
5. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

Parent/ Guardian Name:_____ Date:_____

Parent/ Guardian Name:_____