Sugar Land Neopeds Care

SONIA CHAUHAN M.D

Authorization To Disclose Health Information

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name:_____ Date of Birth: _____

I authorize the following individual or organization to disclose the above named individual's health information:

To: Sonia Chauhan M.D
7616 Branford Place, Suite 150 Sugar land, TX 77479
T: 832-939-9070 Fax: 281-727-0216

From:
Doctor Name/ Organization_____
Address:_____ City:_____ State:_____ Zip Code:_____
Telephone Number: _____-_____-_____ Fax: _____-_____-_____
For the purpose of: _____

I specifically authorize the use and disclosure of the following: **(please circle all the apply)**

Consult Records	Immunization Record	ADHD Reports
Laboratory Results	Radiology Reports	Entire Medical Record

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
__ Yes, I consent to the release of this information. **__No, I do not consent to the release of this information.**

_____ _____
Signature of Parent or Legal Representative **Printed Name**

_____ _____
Relationship to Patient (if Legal Representative) **Date**

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:
I understand that my medical record may contain reports, test results, and notes that only physician can interpret. I understand and have been advised that I should contact my physician regarding the entries. I will not hold Sugar land Neopeds Care liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient(if Legal Representative) Witness

Date request completed _____ # of copied _____ Reviewed By:_____ Charges $_____ Cash _____ Check #_____Initials: _____

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