

Stone Oak Pediatrics



Helping Grow Healthy Kids

Authorization for Release of Confidential Information

Patient Name: _____ DOB: ____/____/____

Patient Name: _____ DOB: ____/____/____

Patient Name: _____ DOB: ____/____/____

Address: _____ City, State: _____

Zip Code: _____

Release FROM: Stone Oak Pediatrics

Release TO: _____

540 Oak Centre #200

Name

San Antonio, Tx, 78258

Fax #

Phone: (210) 403-2229

Fax: (210) 403-2524

Phone #

Please check:

 X All records.

I authorize above listed physician to release medical information including, if any, psychiatric or psychological information, infectious or contagious disease information (including HIV/AIDS confidential information), and/or about drug or alcohol abuse or treatment, of same from the health records. I understand that this consent shall automatically expire thirty (30) days from the date set forth below and I may revoke this authorization in writing at any time prior to the expiration date.

Parent/Legal Guardian Name (PRINT)

Parent/Legal Guardian Signature

Date: ____/____/____