Stone Oak Pediatrics

Authorization for Release of Confidential Information

Patient Name: ________________________________ DOB: ____/____/____

Patient Name: ________________________________ DOB: ____/____/____

Patient Name: ________________________________ DOB: ____/____/____

Address: ____________________________________ City, State:______________
Zip Code:____________

Release FROM: ________________________
Physician/Office name

____
Phone#

____
Fax #

____
Address

____
City, State, Zip Code

Release TO: Stone Oak Pediatrics

540 Oak Centre #200
San Antonio, Tx, 78258

Phone: (210) 403-2229
Fax: (210 403-2524

Please check:

____X____ All Records (Notes and Labs)

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: ____/_____/______