GROW Pediatrics & Adolescent Medicine, PLLC
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P: 512-467-7334 | F: 512-467-7335
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AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION TO SCHOOL/DAYCARE

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY— INCLUDING ATTACHMENTS— SO THAT WE MAY PROCESS YOUR REQUEST

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:
Date of Birth:	Contact Number:	
Street Address:	City, State, & Zip Code:	

INFORMATION TO BE RELEASED FROM GROW PEDIATRICS

- ☐ Statement of Good Health
- ☐ Immunization Record
- ☐ School Excuse Note
- ☐ Allergy/Asthma Action Plan *(circle one)*
- ☐ Medication Authorization
- ☐ School/Daycare Specific Form
- ☐ Other:______________________________
  ____
  ____

INFORMATION TO BE RELEASED TO:

☐ Send by Mail ☐ Fax ☐ Secure Email

Organization/Person:	
ATTN:	
Street Address:	City, State & Zip Code:
Phone:	Fax:
Email Address:	

AUTHORIZATION FOR GENERAL RELEASE OF INFORMATION

I understand that:

- Authorizing the disclosure of this healthcare information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can cancel this authorization by any time by written notification to GROW PEDIATRICS AND ADOLESCENT MEDICINE, PLLC. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further releases or distribution by the recipient that may not be protected by confidentiality laws.
- This authorization will expire 90 days from the date signed below unless another date or event is entered here: __________________________

SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE

____

Signature of Patient/Parent/Legal Representative Date

____

Printed Name of Parent/Legal Representative Relationship to Patient

FOR OFFICE USE ONLY

	Date	Staff Initials
Received/Paid	AM / PM	
Fulfilled	AM / PM	

Fee	*Amount*	*Turnaround Time*
☐ Standard	$10	1 week
☐ Expedited	$25	< 1 week

Rev. 03-2018