1473 N. Lee Trevino
El Paso, TX, 79936
Phone: 915-280-9267
Fax: 915-249-4262

Authorization for Release of Medical Information

Patient Name: ____ DOB: ____/____/_______

I hereby authorize the entity listed below to release medical information to Desert Bloom Pediatrics:

Doctor/Clinic/Hospital: ____

Address: ____

Telephone: ___________________________________ Fax: ___________________________

Medical information requested for treatment/continuing medical care:

□ All Records
□ Specific Records from____________ to ____________
□ Immunizations & Physical Examinations
□ Radiology Reports (X-ray, Ultrasound, CT, MRI, etc)
□ Other (specify): ______________________________

If you wish for certain information to **NOT** be included, please list below:

____
____

Signature of Parent or Legal Guardian: ________________________________ Date: ___/____/_____

Print Name: _________________________________ Relationship to Patient: ____________________

Patient's signature (if over age 18): ____

This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time and that it must be done in writing unless the facility, which is to make the disclosure of information, has already done so in reliance on the statement.