

KILLEEN PEDIATRIC CARE CLINIC, PA
4102 S CLEAR CREEK RD SUITE 107
KILLEEN, TX 76549
Phone 254-526-8300 Fax 254-526-4828

Patient Name	Birth Date	Social Security Number
Address		Telephone Number
<p>I hereby authorize (Physician/Facility Name) _____ To release information (by fax or mail) from the medical record of the above mentioned patient to: Physician/Facility Name & address or fax#: _____</p>		
For the following purpose or treatment:		
<input type="checkbox"/> H & P	<input type="checkbox"/> Immunization Record	<input type="checkbox"/> Current Information
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Other
<input type="checkbox"/> Labs	<input type="checkbox"/> All Records-Changing Primary Care Physician	
Type of Access Requested:		
<input type="checkbox"/> Copies of Records <input type="checkbox"/> Inspection of Records		
This authorization expires 90 days from the date signed below and covers only treatment for the dates or diagnosis specified above.		
<p>I acknowledge and consent to such that the released information may contain but is not limited to the _____ following information: alcohol and drug results, sexually transmitted diseases and HIV results. (Initials)</p>		
<p>I, the undersigned, have read the above and authorize the staff of KPCC to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I understand the re-disclosure of this information to a party other than the designated above is forbidden without additional authorization on my part. This facility is released and discharged of any liability and the undersigned will hold the facility harmless, for complying with this "Authorization for Release of Medical Information." Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for (1) conducting research-related treatment, (2) obtaining information in connection with the eligibility for enrollment in a health plan, (3) determining an entity's obligation to pay a claim, or (4) creating health information to provide to a third party.</p>		
Date:		
Patient Parent or Guardian Signature:		
Witness Signature:		
For Office Use Only		
Date Received:	Processed by:	
Date Processed:	Please circle: By fax By Mail Pick Up	