



LUV-N-CARE PEDIATRICS

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient: _____

Date of Birth: ____/____/____ Phone Number (____) _____ SS# _____

Address: _____

City: _____ State _____

Zip: _____

By my signature below, I hereby authorize Luv-N-Care Pediatrics to use or disclose the specific protected health information identified herein for a purpose other than treatment, payment or health care operations. I understand that this information will be given only to those identified on this form and that there is a period which no further disclosure may be made without further authorization from me. I also understand that this authorization may allow the recipient of my health information to pass it on to others, so it may no longer be protected under federal law. I understand that I have the right to revoke this authorization at any time through written notice which must be mailed or faxed to:

LUV-N-CARE PEDIATRICS
11037 FM 1960 West
Suite B-2A
Houston, Texas 77065
PH 832-237-8882 Fax 832-237-8886

Information to be released includes and is limited to:

____ Medical Records ____ Immunizations ____ Medications ____ Test results ____ Hospital Stay
____ Hospital Records ____ Laboratory reports ____ Operative reports ____ Pathology reports
____ X-rays ____ Billing Records

This information will be used for the following purpose: _____

This information should be mailed/given/faxed to: _____

Add: _____

City: _____ State: _____ Zip: _____ fax(____) _____

I understand that this authorization will expire 90 days from the date of my signature below. After this period Luv-N-Care Pediatrics would need a new authorization before releasing any further information.

Signature: _____ Date: _____