LUV-N-CARE PEDIATRICS

11811 Fallbrook Dr., Suite B-2
Houston, Texas 77065

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 that 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
11811 Fallbrook Dr., Suite B-2
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:_____