

Village Pediatrics Waco PLLC  
4515 Lake Shore Dr  
Waco, Texas 76710

AUTHORIZATION FORM  
RELEASE OF MEDICAL INFORMATION

Name of Patient: \_\_\_\_\_ DATE: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State & Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

*Information to be released: \*\* Reports may include information on drug/alcohol/psychological/HIV or communicable disease treatment\*\*.*

History & Physical \_\_\_\_ Progress Notes \_\_\_\_ Consultations \_\_\_\_  
Radiology/MRI/CT \_\_\_\_ Laboratory \_\_\_\_ All Reports \_\_\_\_  
Other \_\_\_\_ Please specify: \_\_\_\_\_

**PURPOSE OF RELEASE:** \_\_\_\_ Continuing Medical Care \_\_\_\_ Personal Records  
\_\_\_\_ Other, please specify: \_\_\_\_\_

RELEASING PROVIDER:

Name of Provider/Facility: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State & Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

AUTHORIZATION:

Name of Parent/Guardian/Executor: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Signature of Authorization: \_\_\_\_\_ Date: \_\_\_\_\_

\*In addition to this authorization, I understand that I may revoke this consent anytime, except to the extent that action has already been made before receipt of revocation. This authorization expires automatically one hundred eighty (180) days from the date of signature or otherwise specified. I understand that I may be charged for copies of my medical records. I understand that these records are protected under federal/state law and cannot be disclosed without my consent otherwise provided by law. Releasing office will not be responsible for dissemination or disclosure of your confidential medical information once we provide such information, at your request, to your health insurer, employer, attorney or other designee.

Phone: 254-269-3099  
Fax: 877-569-2842