Aquarius Pediatrics
Growing Happy Families

11515 Toepperwein Road, Suite 203
San Antonio, Texas 78233

Phone: 210-560-4500
Fax: 210-504-2388

www.aquariuspediatrics.com

Authorization for Release of Medical Information

Patient Name: _____

Date of Birth: _____

I, _____, hereby authorize the release of medical information **TO** :

Aquarius Pediatrics
11515 Toepperwein Rd, Suite 203
San Antonio, TX 78233
Phone 210-560-4500 Fax 210-504-2388

FROM:

Doctor/Clinic/ Hospital: _____

Address:_____

_____

Phone: _____ Fax: _____

Please release the following:
___ All health information (including growth charts and vaccination records)
___ History/ Physical Exam
___ Progress Notes
___ Discharge Summary
___ Consultation Reports
___ Other (specify) : _____
___ Diagnostic Test Reports
___ Radiology / Images
___ Lab Results
___ Pathology Reports

I consent to the release of information related to HIV/AIDS or infection with any other communicable diseases, and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical records.

___ Yes, I consent to the release of this information
___ No, I do not consent to the release of this information

Purpose of Disclosure: ___ Treatment / Continuing medical care

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

Signature: _____ Date: _____

Print Name : _____

Relationship to Patient : _____