

**Almouie Pediatrics  
Authorization for Release of Medical Records**

I authorize the following protected health information to be released from the medical record of:

DATE \_\_\_\_\_

LAST NAME (PLEASE PRINT) \_\_\_\_\_ FIRST NAME \_\_\_\_\_ DOB \_\_\_\_\_ ACCT # \_\_\_\_\_

PHONE NUMBERS \_\_\_\_\_

**RELEASE OF RECORDS:**

**RELEASE RECORDS:**

- FROM ALMOUIE PEDIATRICS
- TO 14041 NORTHWEST BLVD STE. 1  
CC TX. 78410  
Phone:361-767-9963 Fax: 361-767-1382

PHYSICIAN/FACILITY \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

\_\_\_\_ Please mail my records    \_\_\_\_ Call when records are ready    \_\_\_\_ Fax

I understand that to the extent any recipient of this information, as identified above, is not a "covered entity" under Federal or Texas privacy law, the information may no longer be protected by Federal or Texas privacy law once it is disclosed to the recipient and therefore, may be subject to re-disclosure by the recipient.

**To Be Released**

**Dates of Service**

- Office visits and lab \_\_\_\_\_
- Nuclear/Imaging \_\_\_\_\_
- Physical Therapy Notes \_\_\_\_\_
- Urgent Care Visits \_\_\_\_\_
- Entire Record \_\_\_\_\_

Reason for Release of Information:

- At the request of the individual
- Other (Describe reason for Disclosure) \_\_\_\_\_

**Fee Schedule**

- Medical Records Pages 1-20 \$25.00 for the first 20 pages \_\_\_\_\_
- Pages 20+ \$.50 per page (after first 20 pages) \_\_\_\_\_ #of pages \_\_\_\_\_
- FMLA/other forms \$25.00 \_\_\_\_\_
- Attorney/Affidavit Medical Records \$50.00 \_\_\_\_\_

**Total Amt due** \$ \_\_\_\_\_

I understand that this authorization is valid for six months unless I notify Almouie Pediatrics otherwise. I may revoke this authorization in writing at any time except to the extent that Almouie Pediatrics has already relied on this authorization. I may revoke it by mailing or faxing a written notice to Almouie Pediatrics to the address/fax number above stating my intent to revoke this authorization. I understand that the records released may include information relating to Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care. I understand my treatment will not be conditioned by my completion of this form. I will be responsible for any fees associated with the request before the records are delivered. The information will be provided to me within 21 days of my request.

Note: If mailing or faxing this form, please include a copy of your photo ID.

\_\_\_\_\_  
**SIGNATURE OF PATIENT (OR LEGAL GUARDIAN)**

\_\_\_\_\_  
**DATE**

**Almouie Pediatric Staff Use Only**

I have verified the patient's account number and notified him/her of the fee.

**Date Released** \_\_\_\_\_ **Released by:** \_\_\_\_\_

**Notes:** \_\_\_\_\_