

Authorization for Release

Request of Protected Health Information (PHI)

Prepayment Charge: There is a prepayment charge of \$6.50 per child for more records to be placed on a disc and mailed, in accordance with Texas Health and Safety Code \$241.154. **(Option A below)**

Patient Name	Date of Birth
Patient Name	Date of Birth
Patient Name	Date of Birth
Phone Number	
Address:	
☐ I authorize Sunflower Pediatric Clinic OR	☐ I authorize Sunflower Pediatric Clinic to
release information to:	to obtain information from:
Name of Provider or Facility/or Parent Name	
Address	
City, State, Zip Code	
Phone # / Fax # (Include Area Code)	
What information can be disclosed? Please sele	•
□ Option A (prepayment required): Full Medica	
□ Option B (no charge): Immunization Record, (Growth Chart, and Chart Summary (when available)
REASON FOR DISCLOSURE (Choose only one of	ption):
☐ Treatment/Continued Patient Care ☐ Personal	•
Signature of Individual or Legal Authorized Repr	esentative Date
Relationship to individual: \square Parent of Minor \square 6	Guardian □ Other
A minor individual's signature is required for the release of certain information related to certain types of reproductive care, sexually mental health treatment (See, e.g., Tex. Fam. Code § 32.003)	
Signature of Minor	 Date

In accordance with state law and regulatory agency requirements, the health record is the property of Austin Health Partners. HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing an insurance or health maintenance organization function, or as may be otherwise authorized by law