Transfer of Medical Records Authorization

PATIENT:_____ DOB:_____

Please send information, including diagnosis and records of any treatment or examination rendered, to:
Favor de enviar informacion, inclusive diagnosis y record de todo tratamiento o examen realizado,a:

☐ TO: ABC Pediatric Clinic PA

13711 Wallisville Road
Houston, TX 77049
Phone: 713-455-7777
Fax: 713-453-7337

☐ FROM: ABC Pediatric Clinic PA

13711 Wallisville Road
Houston, TX 77049
Phone: 713-455-7777
Fax: 713-453-7337

From:

To:

I hereby authorize you to release information including the diagnosis and records of any treatment or examination rendered to ABC Pediatric Clinic. I am aware that the records released may contain information relating to psychiatric or psychological testing, physical testing, physical abuse, or drug and/or alcohol abuse.

He aqui doy mi autorizacion para la transferencia de informacion medica, inclusive el diagnosis y record de todo tratameinto o examen relizado, a ABC Pediatric Clinic. Reconozco que es posible que la record transferida contiene informacion relacionada a pruebas psicologicas o de psiquiatria,prueba fisica, abuso fisico, o abuso de drogas o de alcohol.

Guardian Signature:_____