Valley Children's Clinic, P.A. or Harlingen Family Night Clinic

2226 Haine Drive, Harlingen, Texas 78550
Phone: (956) 423-1283 Fax: (956) 412-3033

Patient Name	Birth Date	Social Security Number
Address		**Telephone Number**

I hereby authorize: _____

_____

_____

To release information (by fax or mail) from the medical record of the above mentioned patient.

To: _____

_____

_____

For the following purpose or treatment: _____

Type of Access Requested: ☐ Copies of Record ☐ Inspection of Record

This authorization expires 90 days from the date signed below and covers only treatment for the dates or diagnosis specified above.

☐ H & P ☐ Immunization Record ☐ Current Information

☐ Progress Notes ☐ Consultation Reports ☐ Other _____

☐ Labs ☐ All Records Changing Primary Physician _____

_____ I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, and AIDS information.
Initials

I, the undersigned, have read the above and authorized the staff of VCC or HFNC to disclose such information as herein contained. I understand that this consent may be withdrawn by me, in writing, at any time except to the extent that action has been taken in reliance upon it. I understand the re-disclosure of this information to a party other than the designated above is forbidden without additional authorization on my part. This facility is released and discharged of any liability and the undersigned will hold the facility harmless, for complying with this "Authorization for Release of Medical Information".
Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for (1) conducting research-related treatment, (2) obtaining information in connection with the eligibility for enrollment in a health plan, (3) determining an entity's obligation to pay a claim, or (4) creating health information to provide to a third party.

Date: _____

Patient, Parent, or Guardian's Signature: _____

Witness Signature: _____

FOR OFFICE USE ONLY

Date Received: _____ Processed By: _____

Date Processed: _____ ☐ By Fax ☐ By Mail ☐ Pick Up