



18057 Hwy. 105 West, Suite 220, Montgomery, Texas 77356  
www.LakeAreaPediatrics.com

## HIPAA Authorization for Release of Information Form

I hereby authorize use or disclosure of protected health information about me as described below. The following specific person or class of persons or facility is authorized to make the following requested use or disclosure: (From whom we need records.)

The following person or class of persons may receive disclosure of protected health information about me:

MAIL RECORDS TO:

**Lake Area Pediatrics**  
**18057 Hwy 105 West, Suite 220**  
**Montgomery, TX 77356**

**936-582-5620 FAX 936-582-5621**

RECORDS ON (PATIENT NAME): \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

Specific description of information to be released:

ALL RECORDS INCLUDING VACCINATION RECORDS  
or  
 SPECIFIC DATES OF SERVICE ONLY (list dates)

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and then would no longer be protected by federal privacy regulations.

I may revoke or withdraw this authorization by notifying Lake Area Pediatrics in writing of my desire to revoke it. However, I understand that any action already taken in advance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

This authorization will expire on \_\_\_\_\_, or one year after the date of said authorization.

**THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.**

\_\_\_\_\_  
Signature of Individual or Guardian

\_\_\_\_\_  
Date of signature

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Guardian's relationship to minor

A copy of this completed, signed, and dated form must be given to the individual or person signing on the individual's behalf.