Houston Specialty Clinic
Pediatric Neurology | Pediatric Pulmonology | Pediatric and Adult Sleep Medicine
The Offices of Dr. Joshua Rotenberg, Dr. Sarat Susarla and Kara Schmidt, PA-C, RD

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name: _____ DOB: _____
I authorize the following individual or organization to disclose the above named individual's health information:

NAME: _____

ADDRESS: _____
This information may be disclosed TO and used by the following individual or organization:

NAME: _____

ADDRESS: _____
For the purpose of:
Please release the following: ___ Entire record **OR:**
___Problem List __Genetic testing information __Medication List __Allergies __Progress Notes __H&P
___X-Ray/Imaging Reports-from (date) _____ to (date) _____
___Laboratory Results-from (date) _____ to (date) _____
___Other diagnostic reports_____
___Other (specify) _____
I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
__YES, I consent to the release of this information __NO, I do not consent to the release of this information

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or 30 days from the date of this request.
I understand that authoring the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the office manager.

_____ _____ _____ _____
Signature of patient/guardian | Please print name | Date | Relationship to patient

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:
I understand that my medical record may contain reports, test results and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Houston Specialty Clinic liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____ _____ _____
Signature of patient/guardian | Please print name | Date | Relationship to patient