Sugar Land Med-Ped Clinic

3533 Town Center Blvd South, Suite 100

Sugar Land, Texas 77479

DESIGNATION AND DIRECTION FOR RELEASE OF MEDICAL INFORMATION

I_____________________________ (PT NAME) hereby authorize my Protected Health Information to be discussed/disclosed as necessary to the person named below as required for my medical treatment.

Personal Representative: 1.________________________ Relationship_________________ Contact___________

2.____ Relationship_____________________ Contact__________

Circle: Y for Yes / N for No

Y/N It is permitted to leave a message WITH THE PERSON ABOVE REGARDING MY APPOINTMENT.

Y/N It is permitted to leave a message WITH THE PERSON ABOVE REGARDING MY LAB RESULTS.

Y/N It is permitted to leave a message WITH THE PERSON ABOVE REGARDING MY MEDICAL RECORDS.

Circle: Y for Yes / N for No

Y/N It is permitted to leave message on my answering machine regarding MY APPOINTMENT.

Y/N It is permitted to leave message on my answering machine regarding MY LAB RESULTS.

Y/N It is permitted to leave message on my answering machine regarding MY MEDIAL RECORDS.

Signed:____

Date:____

Witness:____