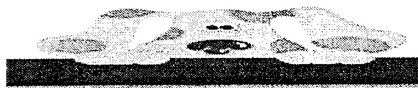

CHILDREN'S CENTER OF VICTORIA
INANTS,CHILDREN AND ADOLESCENTS
4304 N.LAURENT
VICTORIA, TX 77901
(361)573-4313 FAX (361)573-4327

Yogesh C.Dhingra,M.D.,P.A.

Authorization for Disclosure/Access of Protected Health Information

I hereby authorize ______________________________to disclose the following protected health information to the following individual/health care facility. I understand the release of my protected health information could be shared with agencies or business who may not be covered by federal law.

Person/Physician/Health Care Facility:____

Address:_________________________________ City:_________________ State:___________ Zip Code_________

I hereby authorize the disclosure/access of protected health information on:

Patient's Name:_________________________________ Date of Birth:________________

Address:___________________________________ City:_________________ State:__________

Zip Code:________________.

Admit & Discharge Dates:____

I hereby authorize the disclosure/access of the following protected health information,including,if applicable, any test results or treatment for alcohol and/or drug abuse, behavioral health services/psychiatric care, or reportable communicable and/or sexually transmitted diseases, including acquired immune deficiency syndrome or human immune-deficiency virus infection.

______ Immunization record ________ Progress Notes ________ Radiology Report

_____ Laboratory Report _______ Complete Record

The above personal health health information is requested for the following purpose and the purpose and that purpose only:

_______Personal Reasons ______ Insurance Claims ______ Further Treatment ______Litigation

_______ Other:__________________

I understand that I may revoke, in writing, this authorization at any time but not retroactive to the disclosure of personal health information made in good faith. I also understand this authorization will expire in 180 days from the date of my signature.

Patient Signature:____ Date:__________________

Next of Kin/Legal Guardian/Representative:___________________________________ Date:_____________

Witness Signature:____ Date:_________________