Luis A. Lopez, MD, PA
Little Buddies Pediatric Clinic

20642 Stone Oak Pkwy, Ste 105
San Antonio TX, 78258
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Authorization for Use and Disclosure of Protected Health Information
Autorización para el Uso y Divulgación de Información de salud protegida

Patient Information (Información del Paciente):
Name:_____Date of Birth:__/____/____
Address: _____
Phone: (_____)_____-_____ Mail ( ) Pick up ( ) Fax ( )

Please Release information from ( ) to ( ):
_____
_____
_____
_____

Please Release information to ( ) from ( ):
Luis A. Lopez, MD, FAAP
20642 Stone Oak Pkwy, Ste 105
San Antonio, TX 78258
Phone: (210)-650-0814 Fax: (210)-650-0926

Information to be released:
( ) All Medical Records ( ) Hospital Records ( ) Lab Reports
( ) Immunization Record ( ) Radiology Reports ( ) Progress Note
( ) Treatment Notes from____/____/____thru____/____/____

Purpose of Disclosure:
( ) Transfer of Care ( ) Billing and Insurance Purpose
( ) Other: _____

Drug/Alcohol/Psychiatric/HIV/AIDS Record Release
I understand that the requested information may contain reference to or result of HIV/AIDs Virus testing and/or treatment, as well as information regarding drug, alcohol abuse, psychiatric diagnosis and treatment, Sexually Transmitted Diseases, Infectious Diseases such as Hepatitis B or C, and other sensitive information**. I authorize the release of such information to the indicated party, unless prohibited in my instructions above.**

Time Limit and Right to Revoke Authorization
Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization **by submitting a Written Notice** to our office at the address above. Unless revoked, this authorization will expire 90 (ninety) days after the date of signature.

Re-disclosure
I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. Our office, its employees, officers and Physicians are hereby released from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Fee for Copying Requested Information: I understand that there may be a fee charged for copying of requested information. I have been notified of this policy and agree to pay accordingly._____(Please Initial)

Signature of Patient or Legal Representative Authorizing Disclosure:
I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form. I can receive a copy of the Protected Health Information to be used and disclosed. I authorize Little Buddies Pediatrics Clinic to use and disclose the information specified above.

Signature:_____Relationship to Patient: _____

ID:_____Date: _____

Witness:_____Date: _____