# Release of Medical Records


**Bloom Pediatrics**

**Ramona Ataya-Dakour MD, FAAP**
**Rebecca Balfanz, APRN, CPNP**
**3070 College Street Suite205 Beaumont, Texas 77701**
**Tel: 409-832-1225 Fax: 855-638-6067**


Previous Pediatrician/Provider Information:

Doctor/Provider Name: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Parent/Guardian Information:

I, _____, authorize the release of my child/children medical records named below:

Patient Information:

Name: _____ D.O.B.: ____/____/_____
Name: _____ D.O.B.: ____/____/_____
Name: _____ D.O.B.: ____/____/_____
Name: _____ D.O.B.: ____/____/_____

**Specific information to be disclosed**

| | |
|---|---|
| O | Entire Medical Record |
| O | Immunization Record |
| O | Labs/Imaging |
| O | Consult Notes |

**The undersigned understands and acknowledges that:**

- He/she has the right to end the authorization by submission of a written request to the doctor or medical group listed above. Uses and discloses(releases) made between the authorization date and the date of ending or expiration date are permitted and approved by the undersigned.
- The doctor or medical group listed above is prohibited from conditioning treatment, payment, or enrollment upon giving authorization.
- The information released may be subject to re-disclosure (release) by the recipient and may no longer be protected by privacy law.

_____ _____

Signature of Patient or Guardian Date:

**Notice to the individual giving this authorization**

This authorization shall operate as a complete release of liability of Dr. Ramona Ataya-Dakour's Office, its officers, agents and employees for the release of information as specified above. We have no control over the recipient's use of the information. The person who we disclose your information may disclose it to someone else and this office will no longer be able to protect the information.