AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

I request and authorize: ____
to release the medical records of the following patients to:

Honeybee Pediatrics
Whitney Bethel Morgan, M.D.
515 N. King Street #101
Seguin, TX 78155
Phone: 830-372-3135
Fax: 830-372-3716

Name of the patient ___________________________________ Date of Birth________________

___________________________________ Date of Birth________________

___________________________________ Date of Birth________________

This request and authorization applies to:

________ All health care information

________ Health care information related to the following treatment, conditions or dates of treatment:

____

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I understand that my express consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV, AIDS virus, sexually transmitted disease, psychiatric disorders/ mental health and drug and/ or alcohol abuse. If I have been tested, diagnosed and/or treated for HIV, AIDS virus, sexually transmitted disease, psychiatric disorders/ mental health and drug and/or alcohol abuse you are specifically authorized to release all health care information relating to such testing, diagnosis and/ or treatment.

__________________________________ __________________
Signature of patient/parent/guardian Date

____
Printed name of patient/parent/guardian

____
Relationship to patient Incoming Records

Incoming Records