(866) 219-8595
AsYouAre.com

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

Parent Name: _____ Phone: _____

Address: _____

I authorize:

As You Are
110 E. Houston St. Suite 202
San Antonio, TX 78205
Phone: 866-219-8595

To release my child's protected health information (as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to: (New Doctor, Lawyer, Parent, School, Daycare, Therapy Center, etc.)

Name: _____

Address:_____

Email: _____

Telephone:_____

Fax:_____

The purpose of this request is:

Further Medical Care Personal Other: _____

I authorize the release of the following protected health information:

Entire Record Other: _____

I understand that this authorization will expire one (1) year from the date on which it was signed. I understand I may revoke this consent at any time by contacting support@asyouare.com; however, that will not affect disclosures made in reliance on this Authorization. I understand that my child may receive care even if I do not consent to release their health records.

Parent/Guardian Signature:_____ Date _____

Parent/Guardian Printed Name: _____