(866) 219-8595
110 E Houston St., Suite 202, San Antonio, TX 78205
AsYouAre.com

CONSENT TO OBTAIN 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 obtain my child's protected health information (as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")) from my child's previous treating organizations, physicians, and clinicians for the purpose of providing further medical care. I authorize the release of my child's full medical record including, but not limited to: Medical History, Treatment Notes, Prescriptions, Immunizations, Laboratory/X-Ray Reports.

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: ___________________________