Colony Pediatric - Quntao Yu, MD, FAAP
4427 Highway 6, Suite J , Sugar Land, TX 77478
Tel: 281-565-8188 Fax: 281-565-8184

Authorization for Release of Information

I, the undersigned, do hereby request and authorize to release medical records of:

Child Name: _____ Date of Birth____/ ____/ _____

Child Name: _____ Date of Birth____/ ____/ _____

Child Name: _____ Date of Birth____/ ____/ _____

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From: Dr. _____ **To:** Dr. Quntao Yu, MD, FAAP

Address: _____ 4427 Highway 6, Suite J

_____ Sugar Land, TX 77478

Phone: _____ Phone: 281-565-8188

Fax: _____ Fax: 281-565-8184

Information to be released: Reports may include information on drug/alcohol/psychological/ communicable disease treatment:

- ☐ Vaccination Records
- ☐ Laboratory, X-rays
- ☐ Partial medical records (Specify content and/or dates) _____
- ☐ Consultation
- ☐ All medical records

HIV/AIDS. I consent to the release of any positive or negative test for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agents of AIDS, if any, with the rest of my medical records.
Initial; _____ Date _____

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it and that, in any event, this authorization expires **automatically by 12 Months** from the date of signature, unless written revocation is received by the physician prior to that date.

Signature: _____ Date: _____

_____ _____
Print Name of Representative or person legally authorized to sign Relationship to patient.

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