

**Teri Perryman, M.D., P.A.**

513 Granada Place  
Kerrville, Texas 78028  
(830) 896 - 2758

**STANDING CONSENT TO RELEASE  
PROTECTED HEALTH INFORMATION (PHI)**

RELEASE OF VACCINATION INFORMATION

As of the below signed date I ( **do / do not** ) agree to allow the health care provider giving vaccinations to release information about all vaccinations given to me, or to the person for whom I am authorized to consent, to other health care providers, Texas Department of Health and Human Services and schools in order to avoid receiving unnecessary vaccinations and to provide information about what immunizations have been received. I understand that I am not required to agree to the release of this information in order to receive the vaccinations I request. This consent shall be equivalent to a "Release of Medical Records" to the extent that such consent is limited to Vaccination information only and shall never expire except on written rejection by myself or any person authorized to consent for the child(ren) listed. I understand such release will only take place on the verbal request of myself or any person(s) authorized to consent for the below named child(ren).

RELEASE OF PHI TO SCHOOL, DAYCARE, HEAD START or SUMMER CAMPS

As of the below signed date I ( **do / do not** ) agree to allow Teri Perryman, M.D., P.A. to release Protected Health Information about me or my child to any School, Daycare, Head Start program or Summer Camp that request medical information on me or my child. This authorization includes release of information as requested on School, Daycare, Head Start or Summer Camp forms issued by the School, Daycare, Head Start or Summer Camp. I understand that I am not required to agree to the release of this information in order to receive medical care. This consent shall be equivalent to a "Release of Medical Records" to the extent that such consent is limited to Protected Health Information normally found on School, UIL, Camp or Daycare Health Information forms and shall never expire except on written rejection by myself or any person authorized to consent for the child(ren) listed. I understand such release will only take place on the verbal request of myself or any person(s) authorized to consent for the below named children.

I ( **do / do not** ) agree to allow Teri Perryman, M.D., P.A. to Fax the requested information to any entity that I or authorized person(s) shall from time to time verbally request.

I understand that a revocation is not effective to the extent that the practice has already relied on this authorization in its actions. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal HIPAA privacy regulations.

This authorization is effective for each of the following individuals:

- |          |          |          |
|----------|----------|----------|
| 1. _____ | 2. _____ | 3. _____ |
| 4. _____ | 5. _____ | 6. _____ |

\_\_\_\_\_  
Signature of Patient/Personal Representative

\_\_\_\_\_  
Date