coast pediatrics
carmel valley, california

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____

I voluntarily authorize Coast Pediatrics Carmel Valley to release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that Coast Pediatrics Carmel Valley may hold, by means of mail or fax. Release records to:

_____

_____

_____

_____

Please release records to (choose one):

- ○ Patient/parent; I will pick records up
- ○ Directly to the provider listed above

_____ All medical records

_____Medical records with the following exceptions:

_____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____(initial)
Tests for Antibodies to HIV _____(initial)
Psychiatric/Mental Health _____(initial)
HIV Diagnosis/Treatment _____(initial)
Genetic Information/Tests _____(initial)

This authorization will remain in effect for one year from the date that it is signed.Permission for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____ _____
Signature Date

_____ _____
Printed Name Relationship to Patient