



# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

I voluntarily authorize the health care provider named below 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 healthcare providers that the below named health care provider may hold, by means of mail or fax.

**Health Provider(s) to Release Records:**

Provider:	Provider:
Physician:	Physician:
Phone:	Phone:
Fax:	Fax:

**Health Providers Listed Above to Release Records To (choose one):**

- Parent or patient will pick up
- Coast Pediatrics Carmel Valley | Phone: (858) 755-7337 | Fax: (858) 755-7338  
5965 Village Way Suite 201, San Diego, CA 92130

**Health Providers Listed Above to Release (choose one):**

- All medical records
- Medical records with the following exception(s)

**I also consent to the specific release of the following records (initial):**

- Alcohol/ Drug/ Substance Abuse
- Test for Antibodies to HIV
- Mental/ Psychiatric Health
- HIV Diagnosis/ Treatment
- Genetic Information/ Tests

This authorization will remain in effect for one year from the date that it is signed. Permissions 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:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_