coast pediatrics del mar, california

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 Del Mar | Phone: (858) 794-7337 | Fax: (858) 794-7338
12845 Pointe Del Mar Way Suite 200, Del Mar, CA 92014

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
____ Mental/ Psychiatric Health
____ Genetic Information/ Tests
____ Test for Antibodies to HIV
____ HIV Diagnosis/ Treatment

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:**_____