Authorization for Release of Medical Records

Child's Name:____**DOB**:____________________

1. I authorize the use/disclosure of the above named individual's health information as described below.

2. The office/individual where the records are coming from:

Name of *former* physician ***and*** organization requesting records FROM:____________________________

Address: ____

Phone number: (_____)_____-_____________________ FAX: (_____)_______-____________________

3. The type and amount of information to be used or disclosed is as follows:

□ **Complete Medical Record**

□ List of Allergies □ X-Ray Reports □ Physician Progress Notes

□ Problem List □ EKG's □ Lab Reports

□ Medication list

□ **Immunization Record**

□ **Growth measurements/Chart**

□ Consultation Reports From: ____

□ Other (please specify)____

Dates of Treatment: ____

4. Unless otherwise provided by law, records and information concerning the following types of diagnoses, care and treatment will be released *only* if I indicate my specific consent by checking the appropriate box:

□ Alcohol Abuse □ Mental Health Notes

□ Drug and Substance Abuse □ Testing for presence of HIV-Antibodies and/or treatment of AIDS.

5. This information may be released to and used by the following individual or organization:

Garden Pediatrics
101 E. Redlands Boulevard, Suite 106
Redlands, CA 92373
Phone: 909-792-8866 Fax: 909-792-9395
For the purpose of: continuing medical care

6. I understand that I have a right to cancel this authorization at any time. I understand that if I wish to withdraw this authorization I must do so in writing. I must present my written cancellation to the medical records department. I understand that the authorization withdrawal will not apply to information that has already been released due to this authorization. I understand that the cancellation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise cancelled, this authorization will expire after the following date or for the following condition:

If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

7. I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I don't have to sign this form to receive treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the possibility for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact my physician's office manager. I understand that there may be a charge for costs associated with copying my health information.

8. I understand that if Garden Pediatrics is releasing information, they have one week from request to process paperwork.

_____ By initialing here, you authorize Garden Pediatrics to obtain any medical records, as needed.

____ _____________________
Responsible party member's name (please print) ***Relationship***

____ _____________________
Responsible party member's signature ***Date***