Authorization for Release of Information

Federal Regulations require that we first verify and document your identity, the information you would like to use or disclose, and your purpose(s) in requesting this information. You understand that if you request protected health information without patient authorization, we may refuse to provide you access to this information. Thirty (30) days allowed by law to forward/release medical records.

Patient Name: _____ **Date of Birth:** _____

Release Records ☐ **To** ☐ **From** Patterson & Tedford Pediatrics

☐ 7700 Morro Rd, Atascadero, CA 93422 | Ph: 805-466-6622 Fax: 805-466-6603
☐ 230 Station Way, Suite B, Arroyo Grande, CA 93420 | Ph: 805-473-3262 Fax: 805-473-3707

Release Records ☐ **To** ☐ **From**

Name _____

Street _____

City & State _____

Phone _____ Fax _____

Information Requested:
( ) Care Transfer (Last Well Visit, Past 1yr office visits/tests, Immunizations & Growth Charts)
( ) Immunization Record ONLY
( ) Other _____

Note: Hospital Records and Specialist Consultations to be obtained from originator

The purpose(s) for information to be used/disclosed for:
( ) Changing Doctors **( )** Personal Use **( )** Insurance Claim **( )** Attorney/Legal
( ) Moving **( )** School **( )** Continuity of Care **( )** Other _____

Please read and initial:
_____ There are no legal claims/orders pending or in effect that prohibit, limit or otherwise restrict my ability to authorize the use/disclosure of this protected health information.
_____ I understand that, if protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
_____ I understand that a photocopy or fax of this authorization is as valid as the original.

This authorization will expire after this request is fulfilled and shall not extend beyond 180 days from the date of signature.

_____ _____
Signature of Patient or Representative **Today's Date**

_____ _____ _____
Printed Name **Phone Number** **Relationship to Patient**