PREMIER PEDIATRICS
beverly hills

Authorization for Use or Disclosure of Health Information

I, the undersigned, authorize the release of, or request access to the confidential information and records regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, and/or correspondence, including those from my other healthcare providers that the below named health provider may hold, by means of mail, fax, or other electronic methods. I understand the potential for this information to be redisclosed by the recipient and therefore no longer protected by the federal privacy rule.

AUTHORIZATION: I hereby authorize

Premier Pediatrics of Beverly Hills
8907 Wilshire Blvd Ste.250
Beverly Hills, CA 90211
Phone: 310.247.8687 Fax: 310.859.9131

To Release to:

_____
Physician/Healthcare Facility/Patient/Parent

_____
Address/State/City/Zip

_____
Phone Number Fax Number

TYPE OF RECORD REQUESTED: ❑ Complete Medical Record ❑ Immunization Record Only

PURPOSE OF REQUEST: ❑ At the request of patient/patient representative ❑ Transferring to New Physician

❑ Other:_____

DATES OF SERVICE REQUESTED: From:_____ To:_____

State/Federal Laws require specific authorization to release the following types of authorization, I specifically authorize the release of:

❑ Mental Health ❑ HIV test results ❑ Alcohol/Substance Abuse

A separate authorization is required for psychotherapy notes.

This authorization is effective immediately and shall remain in effect until:___MM/___DD/___YY
This document will automatically expire 12 months after the signed date.

I may revoke this request at any time. My cancellation will be effective when it has been received in writing by Premier Pediatrics Beverly Hills. My revocation must be signed and delivered to the address or fax number at the bottom of the page.

_____ _____
Patient Name Patient Date of Birth

_____ _____
Name of Parent/Legal Guardian (Print) Relationship

_____ _____
Signature of Parent/Guardian/Patient (if over 18 years old) Date

Would you like to have records: ❑ Mailed ❑ Picked-Up ❑ Faxed (Immunizations)

MEDICAL RECORD FEE:$25 Each Child.

NOTE: Please be advised that records are provided on CD and may take up to **14 business days** to process