VALLEY PEDIATRIC MEDICAL GROUP, INC.

PETER R. SHULMAN, M.D., F.A.A.P. MARIE T.MEDAWAR, M.D., F.A.A.P.

LYNN S. OSHER, M.D., F.A.A.P. LOUAY KEILANI, M.D., F.A.A.P.

ERIKA CARREON, PA-C

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name:

_____ Date of Birth:_____

Name:

_____ Date of Birth:_____

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct the health care provider(s) named below to disclose my health information during the term of this Authorization to the recipient that I have identified below.

Name of Provider:_____ Fax:_____
Address of Provider:_____
_____
_____

Recipient and Address for Delivery of Records:

Valley Pediatric Medical Group, INC.
5353 Balboa Boulevard, Suite #104
Encino CA, 91316

Phone: (818) 789-7181
Fax: (818) 986-8322

The medical information/records will be used for the following purpose:_____

Information to be disclosed: This authorization permits the above named health care provider to disclose the following medical records:

☐ All of my health information that the provider has in his/her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, *including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and other mental health information, drug/alcohol/other controlled substance information*, billing information, correspondence, and records from my other health care providers that the above-named health care provider may hold.

☐ All of my health information described above except for the following:

_____

_____

☐ Only the following records or types of health information: (Insert dates of treatment, types of treatment or other designation.)

_____

_____

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Term: This authorization/disclosure will remain in effect for one (1) year from the date this form is signed.

Re-disclosure: I understand that once my health care provider discloses my health information to the recipient, they will not re-disclose my health information to a third party. The third party is required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information will be applied.

Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke (at any time) this form for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of my treatment by my health care provider.

Revocation: I understand that this authorization will remain in effect until the term of this form expires or I will provide a written notice of revocation to my health care provider at my health care provider's regular office address. The revocation will be effective immediately upon my health care provider's recipient of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this form before the provider received my written notice of revocation.

Questions: I may contact my health care provider for answers to my questions about the privacy of my health information at my health care provider's regular office telephone number. I understand that I have right to receive a copy of this form from my health care provider.

Photocopy: A photocopy, fax, or electronic copy of this authorization shall be considered as effective and as valid as the original.

_____	_____	_____
Signature	**Date Signed**	**Signature of Witness**

Name:_____
(Please Print)

If individual is unable to sign this Authorization, please complete the information below.

_____	_____	_____	_____
Signature of Personal Representative	Legal Relationship	Date	Signature of Witness