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CHILDREN'S MEDICAL CLINIC
OF SANTA BARBARA, INC.

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AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named above to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

Changing practices/physicians? (circle one) **Yes** **No**

I hereby authorize: _____to release information on
(Physician/Healthcare Facility)

(Patient's Name)_____ **(Patient's DOB)** _____
regarding 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 above named healthcare provider may hold, by means of mail, fax, or other electronic methods.

SEND TO:

_____
Name Phone

_____
Address

_____
City State Zip Code

This authorization is:

[ ] **Unlimited** - ALL medical records and any or all other information regarding medical care, treatment, hospitalization, labs, correspondence, and outpatient care. This release covers any and all conditions including physical and psychiatric conditions, mental illness, behavioral disorders, alcohol and substance abuse, sickle cell disease, HIV, and any other conditions not specifically named.

EXCEPT: Genetic Information: (initial) _____ Psychiatric/Mental Health: (initial) _____
HIV Diagnosis/Treatment: (initial) _____ Tests for Antibodies to HIV: (initial) _____
Drug/Alcohol/Substance Abuse: (initial) _____

[ ] **Immunizations Only**
[ ] **Limited to the following medical information**: _____

RESTRICTIONS
Permission 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 of 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. **Patients 18 yrs. and older must sign form.**

_____ _____ _____
Signature: Patient or Legal Guardian Print Name Relationship to Patient

Phone: _____ Date Signed: _____

Children's Medical Clinic will release one copy of medical records at no charge at the request of patient age 18 years, or parent/guardian. There will be a fee charged for subsequent copies:

REPLACEMENT COPY OF CHART: **$25 AND UP**
REPLACEMENT COPY OF IMMUNIZATION RECORD: **$15**

CMC Use Only: Physician's Signature:_____ Date: _____
Date: _____ Mailed _____ Faxed _____ Emailed_____ Initials: _____