Magnolia Pediatrics of Marin, Inc

Authorization for Release of Protected Health Information

Today's Date: _____

o URGENT. Mark if you have same day doctor's appointment.

Patient Name: _____Date of Birth: _____

Address: _____

Email: _____Phone: _____

I hereby authorize:
Facility/Provider Name: _____

Address: _____

Fax: _____Phone: _____

to release information from the medical record of (Patient Name) _____

This information may be **disclosed to** and used by the following individual or organization:

Name: _____

Address: _____

Telephone Number: _____Fax Number: _____

This authorization will be valid for 180 days from the date it is signed or until, whichever is shorter. This authorization may be received at any time by notifying the above-named provider of information in writing, except when this authorization was obtained as a condition of obtaining insurance coverage. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Information used and disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.

Signature of Patient or Legal Guardian: _____

Relationship to patient: _____

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