

AUTHORIZATION FOR RELEASE OF INFORMATION

SECTION A: Must be completed for all authorizations. I authorize the use/disclosure of my information as described below. This authorization is voluntary, and I understand that all records (written, oral, or electronic) are confidential and cannot be disclosed without prior authorization, except as provided by law. A photocopy or fax of this authorization is as valid as the original.

Fees: (are assessed based on your insurance)

- \$5 fee for individual forms

- \$25 fee for the entire medical record (waived if sent directly to a doctor's office)

Email: Medical record requests may be emailed to medicalrecords@centralcoastpeds.com. Complete records will never be sent via email and partial records are only sent when allowed by HIPAA privacy rules.

Adult patients: Adult Patients (18+) must request their own records. To release records to a parent or another party, they must list the recipient as the authorized party.

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

☐ To ☐ From - Person(s)/organization authorized to use/disclose the information

Central Coast Pediatrics, Inc. 1235 Osos St. Ste. 100, San Luis Obispo, CA 93401

Phone #: (805) 549-0888

Fax #: (805) 549-8463

Email: medicalrecords@centralcoastpeds.com

☐ To ☐ From - Person(s)/organization authorized to use/disclose the information

Name: _____

Address: _____

Ph/Fax: _____

Email: _____

SECTION B: Need copy of records for (Please check one):

____ Personal Use ____ Moving ____ School ____ Changing Doctors

SECTION C: Check information that may be use/disclosed: (Include dates where appropriate)

☐ Entire Medical Record ☐ Immunization Record ☐ Medication Record

☐ Consultation Report(s): _____

☐ Record of Visit(s): _____

☐ Other: _____

SECTION D: Check which format you want to request:

(Choose one) ____ CD ____ Email ____ Faxed ____ Pick up paper copy at Office

Signature of Patient or Representative

Today's Date

Printed Name

Relationship to Patient

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