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)

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

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

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

Central Coast Pediatrics, Inc. 1320 Las Tablas Rd Ste. D, Templeton, CA 93465
Phone #: (805) 434-3796 Fax #: (805) 434-0134 Email: tempfrontdesk@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