



## **Authorization for Release of Medical Information**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I, \_\_\_\_\_, hereby authorize the release of medical information.

### **TO:**

**Sunshine Pediatrics OC**

**Address: 17877 Von Karman Avenue, Suite 210 Irvine, CA 92614**

**Phone: 949-617-2525 Fax: 949-617-3535**

### **FROM:**

Doctor/Clinic/Hospital: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### **Date range for records**

From \_\_\_\_\_ to \_\_\_\_\_  Most recent visit only

### **Purpose of disclosure:**

Medical Treatment / Continuing medical care  Specialist Referral  Personal Records

School/Camp/Sports Clearance  Other (specify) : \_\_\_\_\_

### **Please release the following (check all that apply):**

All health information (including growth charts and vaccination records)

History / Physical Exam  Discharge Summary  Progress Notes  Consultation Reports

Diagnostic Test Reports    Lab Results    Radiology / Imaging

Pathology Reports    Other (specify): \_\_\_\_\_

I consent to the release of information related to HIV/AIDS, communicable diseases, behavioral or mental health services, genetic information, and treatment for alcohol or drug abuse with the rest of the medical records:

- Yes, I consent to the release of this information.
- No, I do not consent to the release of this information.

**Minor Patient Privacy Notice (California Law)**

Under California law, minors age 12 and older may consent to and control the release of certain confidential medical records, including mental health, reproductive health, substance use treatment, and HIV/AIDS services. If requested records include these services, a separate authorization signed by the minor will be required.

**Does this request include any of the above categories for a patient age 12 or older?**

**No-** This request does not include any of the above categories, or the patient is under age 12.  
Parent/Guardian Initial: \_\_\_\_\_

**Yes-** I understand a separate minor patient authorization is required.  
Parent/Guardian Initial: \_\_\_\_\_

*If Yes, complete the following:*

**Minor Patient Authorization (Required only if Yes is selected above)**

I, \_\_\_\_\_, authorize the release of my confidential medical records as described in this form.

Minor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I understand that I may revoke this authorization at any time by submitting a written revocation request to Sunshine Pediatrics OC. Otherwise, this authorization expires after one year from signing.

**Parent / Legal Guardian**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_