



Authorization for Release of Medical Information

Patient Name: _____ DOB: ____ / ____ / ____

Patient Name: _____ DOB: ____ / ____ / ____

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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: _____

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, 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.

Purpose of disclosure:

- Medical Treatment / Continuing medical care
- Other (specify) : _____

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until revoked in writing.

Parent / Legal Guardian

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____