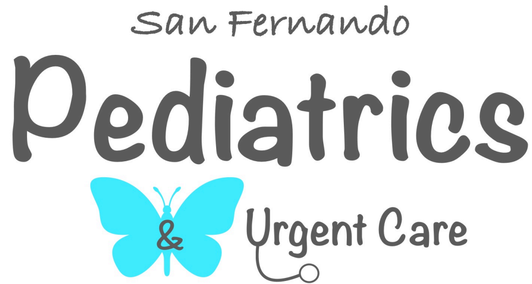

107 N Maclay Ave, San Fernando, CA 91340
Tel: (818) 697-8585 Fax: (888) 799-8585

Authorization for Release of Medical Information

Patient Name: ______________________________________ DOB: _____/_____/______

I, ____ hereby authorize the release of

medical information TO:

San Fernando Pediatrics & Urgent Care
107 N Maclay Ave, San Fernando, CA 91340
Tel: (818) 697-8585 Fax: (888)799-8585

FROM:

Doctor/Clinic/Hospital:____
Address: ____
Telephone: _________________________ Fax: _______________________

Please release the following:

___ **All health information (including growth charts and vaccination records)**
___ History/Physical Exam
___ Progress Notes
___ Discharge Summary
___ Consultation Reports
___ Diagnostic Test Reports
___ Radiology/Images
___ Lab Results
___ Pathology Reports
___Other (specify): ____

I also consent to the specific release of the following records:

Drugs/Alcohol/Substance abuse ________ (initial)
Psychiatric/Mental Health ________ (initial)
Tests for antibodies to HIV ________ (initial)
HIV diagnosis and treatment ________ (initial)
Genetic information ________ (initial)

Purpose of disclosure:

___ Treatment/ Ongoing medical care
___ Coordination of care

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

Signature: ___________________________________ Date: ____/____/______
Patient Name: ____ DOB: ____/____/______
Relationship to Patient:____