THE PEDIATRIC GROUP
OF SOUTHERN CALIFORNIA

Medical Record Release

Medical Release Authorization Form

I hereby authorize and request you to release any and all medical records and other pertinent patient information which may include but is not limited to complete history & physical, lab, and x-ray reports, immunizations, alcohol or drug abuse, HIV, mental health, or communicable disease information or any treatment or examination rendered.

Medical Facility Records Requested from:

Name: ______________________________

Address: _____________________________

____

Phone #: _____________________________

Fax #: ________________________________

Release Records to:

The Pediatric Group and Allergy Group

18370 Burbank Blvd. Suite 307

Tarzana, CA 91356

Fax (818) 996-4712

Email Address: theoffice@thepediatricgroup.net

Medical Records Requested **□ Unlimited** **□ Other:** _____________

□ Mental Health **□Lab/Test Results** **□HIV (AIDES) test/results**
□Follow Up Exams **□Billing** **□Drug/Alcohol use/abuse**

DURATION

This authorization shall be effective immediately and remain in effect until ________________
Date

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

Patients Name: ____ **DOB:** _______________________
Patients Address: ____
Patients Phone #: ____ **Date:** ________________________

______________________________________ ___________________________________
Signature of Patient or Legal Guardian Relationship (if other then patient)