LOS ROBLES PEDIATRIC MEDICAL GROUP
Tammy S. Chi, M.D., Anagha Suresh, M.D., Christopher Tolcher, M.D., Sarah L. Melzer, N.P.
Infants, Children and Young Adults
299 W. Hillcrest Drive, Suite 100
Thousand Oaks, CA 91360
Telephone: (805) 497-7888 Fax: (805) 494-3498
Email: LosRobles-frontoffice@pediatricassociates.com

AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

Please **SEND** Medical Information **TO:**

Los Robles Pediatric Medical Group, Inc.
299 W. Hillcrest Drive, Suite 100
Thousand Oaks, CA 91360

I hereby authorize _____ to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.

Release and/or disclose records and information regarding:

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

Duration: This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for one year from the date of signature if no date is entered.

Revocation: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

Redisclosure: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

Specify records to be released and/or disclosed:
Please initial next to each request

- □ General Medical Information (from_____to_____) _____
- □ Information regarding specific injury/treatment (from_____to_____) _____
- □ X-Ray/Laboratory Results _____
- □ Mental Health _____
- □ Alcohol/Drug _____
- □ HIV Test Result _____
- □ Other (specify):_____

I request that the health information released and/or disclosed pursuant to this authorization be used for the following purposes only: _____
_____
_____

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization.

PARENT IS TO SEND THIS FORM TO THEIR PREVIOUS DOCTOR.

_____	_____	_____
Date	Signature of Patient or Patient's Representative	Indicate Relationship