LOS ROBLES PEDIATRIC MEDICAL GROUP
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AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

Please **SEND** Medical Information **TO:**
Name of Person or Entity to Receive Information:
Title (Physician, Therapist, Attorney, etc.) _____

Street Address: _____

_____

City, State, and Zip Code:

I hereby authorize **LOS ROBLES PEDIATRIC MEDICAL GROUP, INC.** 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 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/Immunizations (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 be released and/ or disclosed for the following reason: ___

_____

_____

_____

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

_____Date_____ _____

Signature of Patient or Patient's Representative

Indicate Relationship (If signed by other than patient)