La Mesa Pediatrics

Record Release Form
Authorization for Use or Disclosure of Health Information

Completion of this document authorizes the disclosure and/or use of the individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

AUTHORIZATION:

I hereby authorize:

La Mesa Pediatrics
8881 Fletcher Parkway, Suite 200
La Mesa, CA 91942
Phone (619) 464-6434 Fax (619) 464-5109

☐ **To release records to:** ☐ **To request records from:**

Name: _____

Address: _____

Phone #: _____

Fax #: _____

Medical Records and information pertaining to medical history, mental or physical condition, services rendered, or treatment for:

Patient: Last Name, First Name: _____
(Please Print)

DOB: _____MRN: _____

Information to be release:

☐ Immunizations ☐ All Records ☐ Other: _____

Reason for request of records:

☐ New PCP ☐ Moving Away ☐ Insurance Change ☐ Other: _____

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I UNDERSTAND that I have the right to revoke this authorization at any time. My revocation must be in writing, signed by me or by my legal representative and delivered to **La Mesa Pediatrics.**

My revocation will be effective upon receipt but will not be effective to the extent that the requester or others have acted in reliance upon this Authorization. I have a right to receive a copy or this Authorization. I will not be required to sign this Authorization as a condition to obtain treatment or payment or my eligibility for benefits.

California law prohibits the requestor from making the further disclosure of health information unless the requestor obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

Print Name: _____
Relationship to Patient: ☐Patient ☐Parent ☐Legal Guardian ☐Other**:** _____

SIGNATURE: _____ **DATE:** _____**TIME:** _____
(Patient/ Parent or Legal Guardian)

*** This authorization becomes void once fulfilled or 12 months after date of signature, whichever occurs first.**

Special Authorization

I specifically authorize the release of (Check all that apply):

___ HIV/AIDS testing ___ Psychological/Psychiatric treatment

___ Drug or alcohol abuse ___ Reproductive health

I understand I am authorizing the release of sensitive/confidential information

Signature: _____Date: _____Time: _____

(Staff Only) Verified ID: _____Date: _____