AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

RECORD RELEASE

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.

I hereby authorize:

____
Physician/Healthcare Facility/Patient/Parent

____
Address

____
City State Zip Code

________________ ________________
Phone Number Fax Number

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To:

Valencia Pediatric Associates

27867 Smyth Drive #100

Valencia, CA 91355

661-294-8399 Fax

I also consent to the specific release of the following records: (From physician only requests).

Drug/Alcohol/Substance Abuse ____________ (Initial)

HIV Diagnosis/Treatment ____________ (Initial)

Psychiatric/Mental Health ____________ (Initial)

Genetic Information ____________ (Initial)

Tests for Antibodies to HIV ____________ (Initial)

Patient Name: ________________________ DOB: ____________

Patient Name: ________________________ DOB: ____________

Patient Name: ________________________ DOB: ____________

Patient Name: ________________________ DOB: ____________

Signature of Parent/Legal Guardian	Relationship *if other than patient*
Name of Parent/ Legal Guardian (Print)	Date