Valencia Pediatric ASSOCIATES

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION
RECORD REQUEST

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 Valencia Pediatric Associates 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 (sent via certified mail only), fax, or other electronic methods.

To:

_____

Physician/Healthcare Facility/Patient/Parent

_____

Address

_____

City State Zip Code

_____ _____

Phone Number Fax Number

Type of record request:

☐ Immunization Record Only ☐ Complete Medical Record

Reason: ☐ App't with Specialist ☐ Transferring to new M.D.

☐ Other _____

27867 Smyth Drive, Suite 100 Valencia, CA 91355
Phone: (661) 294-2229 Fax: (661) 294-8399 www.valpeds.com

Valencia Pediatric ASSOCIATES

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

Would you like to (check one):

☐ Pick-Up ☐ Mail ☐ Fax (Immunization Record Only)

Medical Record Copy Fee ***Mailed***:

$30.00 for 1st child/ $20.00 for each additional child.

Medical Record Copy Fee ***Pickup***:

$20.00 for 1st child/ $10.00 for each additional child.

Immunization Record Copy Fee (mail or fax): $5.00

NOTE: Please be advised that record requests may take up to 14 business day. Records are provided on CD.