Children's Primary Care Medical Group, Inc.

ONE PATIENT PER AUTHORIZATION FORM

Place Patient Label Here

Record Release Form
Authorization for Use or Disclosure of Health Information

Completion of this document authorizes the disclosure and/or use of 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

Children's Primary Care Medical Group
3880 Murphy Canyon Rd., Suite 200
San Diego, CA 92123
Ph (858) 502-1125 Fax: (858) 573-0364 E:cpcmghim@rchsd.org

to furnish to (name and address of recipient)

Name: _____

Address: _____

Phone #: _____ Fax #: _____

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

_____ DOB: _____
(Print last name, first name)

INFORMATION TO BE RELEASED: ☐ Immunization Records ☐ Lab results ☐ Office Visits

☐ Growth Charts ☐Genetic results ☐ Other_____

TREATMENT DATE(s): From: _____ To: _____

PURPOSE: This information supplied is to be used for the following:

☐ Continued care ☐ Personal ☐ School ☐ Legal Matter ☐ Other _____

DURATION: This authorization shall become effective immediately and remain in effect for 12 months from the date signed.

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

Print name: _____ Relationship to Patient: _____

Witness: _____ Verified & Scanned ID_____

Place Patient Label Here

I **UNDERSTAND** that I have the right to revoke this authorization of any time. My revocation must be in writing, signed by me or by my legal representative and delivered to Children's Primary Care Medical Group.

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

Delivery Options:

Release Records: ☐ Flash drive ☐ Paper (**Fees may apply if over 100 pages**)

Records to Be: ☐ Mailed ☐ Delivered via MyChart

☐ Hold for Pickup at Site/Pick up location: _____

Picked up by: _____Time_____Date: _____

To be completed upon pick up

Special Authorization

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

_____HIV/AIDS testing

_____Drug or alcohol abuse

_____Psychological/psychiatric treatment

_____Reproductive health/STDs/STIs

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

****Patients 12-17 years old must sign below to release confidential records****

_____

Sign Time Date