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
Phone: (858) 502-1125 Fax: (858) 573-0364

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: _____ MR#: _____
(Print last name, first name)

Information to be released: _____

USES: This information supplied is to be used for the following purpose(s): _____

_____

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 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 obtaining 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 through MyChart

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

Picked up by: _____Time: _____Date: _____

***Please note that there may be a charge for copying records.**

For translation, please see the front desk staff.

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.

If patient is over 12 years old, the patient must sign below.

_____

Sign Time Date