AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORD INFORMATION

This form is to confirm your authorization to use or disclose your protected health information for a special purpose.

REGARDING RECORDS OF:

Patient Full Name:	Date of Birth:
Address:	Phone Number:
Dates of Treatment:	

INFORMATION TO BE RELEASED FROM:

Name/Agency:	South Area Pediatric Medical Group
Address:	3811 Florin Road Suite 16, Sacramento, California 95823 Phone (916) 394-2580 Fax (916) 424-8302

INFORMATION TO BE RELEASED TO: (Patient must provide all information including address, city and zip code)

Name/Agency:
Address:

FOR THE PURPOSE OF:

INFORMATION TO BE RELEASED: (Check only those that apply)

_____ **Medical Records**
- ____**History & Physical exam**
- ____**Lab / X-ray reports**
- ____**Consultation reports**
- ____**Treatment plans**
- ____**Progress notes**
- ____**Immunization records**

_____ **Psychotherapy Notes**

_____ **Surgical Procedures**

_____ **Psychotropic Medications**

Note: Psychotherapy Notes, Psychotropic Medications, and Surgical Procedures may require patient's signature based on the patient's age.

Description of specific information requested for release not listed above.

- This authorization is effective immediately and is subject to revocation at any time with written notification to the Privacy Officer, except to the extent that action has already been taken. Otherwise, this authorization expires _____ days from the date of signing (Not to exceed one year).
- I realize that this is a required consent and that I must voluntarily and knowingly sign this authorization BEFORE any records can be released, and that I may refuse to sign, but in that event, the records cannot and will not be released.
- I further release my attending physician from any liability arising from the release of information to the person(s) agency as designated above.
- I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Parent or Authorized Representative:	Date:
Print Name:	Relationship to Patient:
Signature of Patient:	Date:

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_____ **Medical Records**
- ___ History & Physical exam
- ___ Lab / X-ray reports
- ___ Consultation reports
- ___ Treatment plans
- ___ Medical Diagnosis
- ___ Progress notes
- ___ Immunization records

_____ **Psychotherapy Notes**
- ___ Psychiatric Evaluation
- ___ Psychological Testing
- ___ Psychological Diagnosis
- ___ Medication Records

_____ **Psychotropic Medication**

_____ **Surgical Procedures**

Note: Psychotherapy Notes, Psychotropic Medications, and Surgical Procedures may require patient's signature based on the patient's age.

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