AUTHORIZATION FOR RELEASE OF INFORMATION

SECTION A: Must be completed for all authorizations. I hereby authorize the use/disclosure of my information as described below. I understand that this authorization is voluntary. I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without prior written authorization except as otherwise provided by law. I understand that a photocopy or fax of authorization is as valid as the original.

Patient Name: _____ **Date of Birth:** _____

Person(s)/organization authorized to use/disclose the information (**FROM**):

_____Central Coast Pediatrics, Inc_____

1235 Osos St. Suite 100, SLO, Ca. 93401

Ph:(805) 549-0888 Fax:(805) 549-8463

Person(s)/organization authorized to receive the information (**TO**):

Name:_____

Address:_____

Ph:_____ Fax:_____

SECTION B: Need copy of records for (Please check one):

____Personal Use _____Moving _____School _____Changing Doctors

SECTION C: Check information that may be used/disclosed:

(Include dates where appropriate)

___ Entire Medical Record

___ Immunization Record

___ Records of Visit (Specific) _____

___ Physical/History Report _____

___ Laboratory Report(s) _____

___Radiology Report(s) _____

___ Medication(s) Record _____

___ Mental Health _____

___ Consultation Report(s) _____

___ Cardiology Report(s) _____

___ Other _____

- **PLEASE DO NOT FAX MORE THAN 15 PAGES. CAN ACCEPT RECORDS ON CD.**
- **Fax # (805) 549-8463**

_____ _____

Signature of Patient or Representative Today's Date

_____ _____

Printed Name Relationship to Patient

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