MANHATTAN BEACH PEDIATRICS
VIVIAN LIU, MD AMIN DAVARI, MD
1200 ROSECRANS AVENUE, SUITE 202
MANHATTAN BEACH, CA 90266
PHONE (310) 335-1411 FAX (310) 414-5775

Please email completed form to
RECORDS@mbpediatrics.com

RELEASE OF MEDICAL RECORDS

Authorization for Use or Disclosure of Protected Heath Information as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Please Print Name(s) and Date(s) of Birth of Patient(s):

Name_____ Date of Birth: _____
Name_____ Date of Birth: _____
Name_____ Date of Birth: _____
Name_____ Date of Birth: _____
Name_____ Date of Birth: _____

Authorization: I authorize Manhattan Beach Pediatrics to use and disclose the protected health information (medical records) described below to the following entity **(please check ONE desired box and complete as necessary)**

☐ UCLA Health Manhattan Beach Pediatrics
1000 N. Sepulveda Blvd, Suite 190
Manhattan Beach, CA 90266
Phone (310) 546-8702
Fax (310) 545-5310

☐ Name: _____
Address: _____
City: _____
Phone: _____
Fax: _____

Effective Period: This authorization for release of information covers all past, present and future periods of health care.

Extent of Authorization: I authorize the release of my complete health record.

Use: This medical information may be used by the entity I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

Termination: Unless otherwise revoked, this authorization shall be in force and effect for 12 months from the date it was signed, at which time this authorization expires.

Revocation Rights: I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

Benefits: I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

Disclosure: Manhattan Beach Pediatrics, UCLA Health System and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your PHI confidential. If you have authorized the disclosure of your PHI to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

_____ _____
PARENT/GUARDIAN'S Signature Date

_____ _____
Printed Name of PARENT/GUARDIAN Email Address

_____ _____
Relationship to Patient (e.g. Mother, Father, etc.) Phone Number