AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information consistent with state and federal laws concerning the privacy of such information.

Print in ink. Failure to provide *all* information requested may invalidate this authorization. Use and disclosure of health information:

I authorize ***Glendora Pediatrics Medical Group, Inc.,*** 210 S Grand Ave. Ste. 202 Glendora, CA 91741,(626) 335-0211 Fax (626) 335-7986 to:

( ) Provide records to: ( ) Obtain records from:

Individual /Agency Name: _____ ( ) Mail
( ) Pick up

Address _____ City _____ State_____ Zip Code_____

_____

Information To Be Released

( ) Complete Medical Records ( ) Immunization Records

Other, Specify _____
( ) HIV test results
_____

I specifically authorize the release of the following:

Purpose

Purpose/ Reason records are to disclosed

( ) Continued Care ( ) Personal use $15.00 ( ) Other, Specify _____

Unless otherwise revoked, this authorization will expire on the following date, event or condition_____. If I fail to specify an expiration date, event, or condition this authorization will expire 90 days from the date of signature.

Signing this form is voluntary. I understand I have the right to revoke this authorization and the right to inspect the material to be disclosed. I request the disclosure above. I authorize use of a copy (including facsimile copy) of this form for disclosure of the information described above.

Patient Name: _____ DOB: _____

Legal Representative Name: _____ Phone#: ( ) _____

Signature, Patient or Legal Representative:_____

Relationship to Patient: _____ Date:_____

(If signed by legal Representative)