PEDIATRIC ASSOCIATES MEDICAL GROUP, INC.
4330 Fulton Avenue Sherman Oaks, CA 91423
(818) 784-1102 (phone) (818) 784-1653 (fax)

RELEASE OF HEALTHCARE INFORMATION

I, _____, authorize to release my minor child(ren)'s medical records for whom I am the authorized representative.

Name _____ DOB _____

Name _____ DOB _____

Name _____ DOB _____

Name _____ DOB _____

□From □To □From □To

Pediatric Associates Medical Group, Inc.
4330 Fulton Avenue
Sherman Oaks, CA 91423

_____
_____
_____

PURPOSE OF THE REQUESTED USE OR DISCLOSURE (which may be subject to copying fees in accordance with state laws):

□Legal □Insurance □Personal □Medical Treatment □Transfer
□Other (please specify) _____

DESCRIPTION OF INFORMATION (check all that apply):

□ Complete Medical Record □ Medical History/Consultation/Evaluation Records
□ Diagnostic Imaging □ Laboratory/Pathology Reports
□ Hospital Records □ Immunizations
□ Summary of Records □ Other (specify):_____

RELEASE OF SPECIFICALLY PROTECTED HEALTH INFORMATION (if applicable): If the information described above includes information in any category below, I specifically authorize the disclosure of such information. Please indicate specific information to be used or disclosed and sign where indicated.

□HIV/AIDS testing □Genetic testing □Records for mental health /Alcohol & drug abuse/STDs

EXPIRATION: This authorization will expire automatically 3 years on the date following signature or event that relates to me or the purpose of disclosure.

INDIVIDUAL'S RIGHTS RELATING TO THIS AUTHORIZATON: I understand I may revoke this authorization by notifying the Medical Records Department at any time in writing, but if I do, it will not have any effect on actions taken by Pediatric Associates Medical Group before they received the revocation. I may refuse to sign this authorization. My health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form (except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party). I have a right to receive a copy of this form after I have signed it. By signing this authorization form, I authorize the use or disclosure of my protected health information as described above. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I have had an opportunity to review and understand the content of this authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

_____ _____
PATIENT'S/REPRESENTATIVE'S SIGNATURE PRINTED NAME

_____ _____
RELATIONSHIP TO PATIENT DATE