



PEDIATRIC ASSOCIATES MEDICAL GROUP, INC.
PRACTICE LIMITED TO INFANTS, CHILDREN, AND ADOLESCENTS

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 AUTHORIZATION: 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