Authorization for Use and Disclosure of Protected Health Information

RAMBLC Pediatric Medical Group

14880 Los Gatos Blvd
Los Gatos, CA 95032
phone (408) 371-7777
fax (408) 371-7147

Patient name: ____________________________ Date of birth: ____________

RAMBLC Physician: _____________________

This form, when signed, gives authorization for RAMBLC Pediatric Medical Group, Inc. to release the indicated type(s) of information from the patient's medical record. Check boxes below indicating which items we may release:

- □ Record of office visits
- □ Lab results (excluding HIV)
- □ X-ray results
- □ Specialist consult reports
- □ Immunization records
- □ Mental health records
- □ Drug/alcohol records
- □ HIV blood test results
- □ Hospital records
- □ Other (specify):

____

Name of persons or facilities to whom the information may be disclosed (i.e. school, daycare, camp, etc.)

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

This authorization is effective indefinitely, unless revoked or terminated by the patient or the patient's personal representative. You may revoke or terminate this authorization by submitting a written revocation to RAMBLC Pediatric Medical Group. Contact your primary care physician to terminate this authorization.

The information that is disclosed under this authorization may be disclosed again by the person or organization to which it has been sent. The privacy of this information, once sent by our office, may not be protected under federal privacy regulations.

Signature ____ Date _______________

Printed name ______________________________________

Relationship to patient ______________________________