Release of Medical Records

RAMBLC Pediatric Medical Group

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

I hereby authorize:

_____
doctor, clinic name

_____
street address

_____
city, state, zip

to disclose to:

_____
doctor, clinic name

_____
street address

_____
city, state, zip

records and information pertaining to:

child(ren)'s names _____ _____
date of birth

_____ _____
date of birth

_____ _____
date of birth

This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here: _____. This authorization is also subject to written revocation by the patient/guardian at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Outgoing medical records are assessed a **25 cent per page copying fee plus postage, maximum $25 per chart.**

Check the box and initial to specify which type of information is to be disclosed:

□ medical information _____ initials

□ psychiatric information _____ initials

□ drug/alcohol testing _____ initials

□ HIV blood testing _____ initials

□ other health information as follows _____ _____ initials

The recipient may use the health information authorized on this form for the following purposes:

_____

Date _____

Signature _____

If signed by other than patient, indicate relationship: _____