AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
FROM: PEDIATRIC ASSOCIATES OF STOCKTON

This authorization allows the release of confidential medical information & records.

I hereby authorize: ***Pediatric Associates of Stockton*** to release information regarding medical history, illness, injury, consultation, prescriptions, diagnosis, treatment, including x-ray and lab reports, and any other records sent to us from outside physicians, hospitals, clinics, etc.

To: ____

____

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This authorization is:

[ ] Unlimited (all records, excluding substance abuse, mental health, HIV diagnosis and treatment

[ ] Limited to a specific visit ____/_____/____ or the immunization record only.

[ ] Limited to financial information for date(s) __________________________.

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _________ (initial)

Psychiatric/Mental Health _________ (initial)

Tests, diagnosis, & treatment for HIV _________ (initial)

Genetic Information _________ (initial)

Duration: This authorization shall be effective immediately and remain in effect for 60 days from the signature date below.

Restrictions: Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained unless such disclosure is specifically required or permitted by law.

A photocopy or faxed copy of this authorization shall be considered as effective and valid as the original.

______________________________________ Signature of patient or legal/personal representative

______________________________________ Relationship to patient

______________________________________ Patient's Name (PRINT)

____/_____/______ Patient's Date of Birth

_____/______/_____ Today's Date

______________________________________ Witness Name

______________________________________ Witness Signature