AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM PEDIATRIC ASSOCIATES OF STOCKTON

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, demographic, & other records sent to us from outside sources for medical treatment. **Name of Patient:** Patient's Date of Birth:

To: _____

_____

_____

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)

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) _____.

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

Today's Date: _____/_____/_____

Witness Name

Witness Signature

Printed by:No data for First Name Pmt?___Cash___Ck___CC/Debit Encounter form?___ Acct #_____.__

* The form MUST be filled out completely.
* We need to have a COMPLETE full address on where the records request is to be sent. Some locations have more than 1 address.
* Indicate what records are being requested: unlimited, specific visit, immunizations or financial information.
* Specific consent is required for drugs, alcohol, HIV, so the form must have the initials of the parent, even if this does not apply.
  failure to do so, may cause a delay in the records going out.
* The form needs to be signed and dated by the parent/guardian. When the patient is 18 or over, the parents CANNOT sign for records.
* All requests must be witnessed and signed.
* If records are to go to the parents, there is a $25.00 charge per patient. This needs to be collected at the time of the request.
* The fee is waived if the records are sent directly to a provider or hospital. If the parents want to "hand carry" the records to the
  specialist, then the $25.00 charge will take place.
* We DO NOT fax or email records, this is against HIPPA compliance
* Consent forms are available either for pick up in the office, fax or email to the parent or they can go on the website at: www.pediatricassociatesofstockton.com under the forms section.

Our goal is to make completing forms and obtaining or sending records as simple and convenient as possible, while still fulfilling all legal requirements.