ELK GROVE PEDIATRICS, INC.
A MEDICAL GROUP
9727 ELK GROVE FLORIN ROAD, SUITE 250
ELK GROVE, CA. 95624-2201
BUSINESS PHONE: 916-686-5003
FAX: 916-686-5015

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize:

_____
Name of Disclosing Party

_____
Address

_____
City State Zip

to disclose to:

_____
Name of Recipient

_____
Address

_____
City State Zip

Records pertaining to:

_____ _____
Name of patient Date of birth

_____ _____
Address Telephone Number

Purpose of disclosing medical records: _____

OR

❑ Provide only pertinent medical records:	❑ All of my medical records from (enter dates):

I understand that the information in my health record may include information relating to sexually transmitted disease, or acquired immunodeficiency syndrome (AIDS). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Expiration: This authorization will become effective immediately and will remain in effect for one year from the date of signature unless a different date is specified here_____ (Date).

California Restrictions: California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

Your rights

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment, payment, or health plan enrollment or legibility for benefits.
- I may revoke this authorization at anytime. My revocation must be in writing, signed by me or on my behalf, and delivered to Elk Grove Pediatrics, Inc.
- My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.

Redisclosure: I understand that the recipient my 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.

I have a right to receive a copy of this authorization.
If the box ☐ is checked, a copy of this authorization was requested and received. _____
Initials

Signature _____ Date_____
Relationship to Patient: _____

Cost: There is a charge of $30 for each chart copied. Payment is expected at time of request. For your convenience, we accept cash, visa, and master card as form of payment.

ATTENTION RECIPIENT: ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSE OF THIS DISCLOSURE.