AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

Prem Pediatrics
657 Camino de los Mares, Suite 243
San Clemente, CA 92673
Office: 949-661-2455 Fax: 949-661-5751

Patient Name: _____Date of Birth:_____

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Medical information released may include information regarding medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, X-rays, correspondence and/or medical records including those from other health care providers that the below named health provider may hold by means of mail, fax or other electronic methods. A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

This authorization is:

[ ] Limited to the following information:_____

[ ] Unlimited (all records: Substance Abuse, Mental Health, HIV and Diagnosis/Treatment)

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

Drug/Alcohol/Substance Abuse: _____ (initial)

HIV Diagnosis/Treatment: _____ (initial)

Psychiatric/mental Health: _____ (initial)

Genetic information: _____ (initial)

Tests for Antibodies to HIV: _____ (initial)

I hereby authorize medical records as stated above to be released as follows:

From: **□ Prem Pediatrics**

Name: _____

Address: _____

City: _____ State: _____ Zip:_____

Tel: _____ Fax: _____

To: **□ Prem Pediatrics**

Name: _____

Address: _____

City: _____ State: _____ Zip:_____

Tel: _____ Fax: _____

I agree to pay a reasonable charge, permissible by law, to cover the clerical costs of making records available for release from Prem Pediatrics. This fee is $20 (twenty dollars). Please, no personal checks. I understand I have a right to receive a copy of this authorization. This authorization is effective now and will remain in effect for 6 months from the date signed below, unless otherwise noted.

_____ _____

Signature of patient, parent, or legal guardian* Today's Date

_____ _____

Printed name of patient, parent, or legal guardian Relationship to patient

*Authorized representative must submit copies of legal documents supporting assignment of this authority