AUTHORIZATION TO RECEIVE OR RELEASE MEDICAL RECORDS

This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act 1981, Section 56 et seq of the California Civil Code.

***ALL FIELDS** MUST BE COMPLETED IN ORDER TO PROCESS THE RECORDS REQUEST**

Patient Name: _____DOB:_____/_____/_____

Patient Street Address:_____

City:_____ State: _____ Zip_____ Phone #(_____)_____

I hereby authorize: **AV Pediatrics, Allergy and Family Medicine**
1523 West Avenue J Suite 7
Lancaster, California 93534
Phone (661) 945 - 2221 FAX (661) 945 - 0831

To release my medical records to:

_____
(Provider or Facility Name)

_____
(Address)

_____
(Phone #) (Fax #)

Disclose:
___All Medical Records (includes all office visits / may contain 2-3 pages per visit)
___Only the Following: □ Labs □ X-Rays □ MRI □ CT □ Immunizations
___Other:_____
___Specific Date(s): _____/_____/_____ to _____/_____/_____

Purpose:
___Personal Use
___Continued Care With Another Provider
___Referral / Request
___Other_____

_____/_____/_____ **_____**
Date **Signature (Patient, Parent, Legal guardian or legal representative)**

1. I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the address above.

2. I may refuse to sign this authorization.

3. I have a right to receive a copy of this authorization.

4. Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. Information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by Federal Confidentiality Law (HIPPA) However, California Law prohibits the person receiving my medical records from making further disclosure of it unless authorization for such disclosure is obtained by me or unless such disclosure is specifically required by law.