Authorization for Use and/or Disclosure of Medical Information to South East Bay Pediatrics

I hereby authorize:

_____

Name of **Previous** Physician or Facility

_____

Address and Telephone Number

to furnish records and medical information concerning:

Patient Name: _____ DOB: ____/____/____

Address: _____

Ph.: _____

***TO*: South East Bay Pediatric Medical Group, Inc.**
2191 Mowry Ave, Suite 600C
Fremont, CA 94538
Ph. (510) 792-4373 Fax. (510) 792-3420

__ Ali Hallaj-pour, MD __ Susan Dugoni, MD __ Dennis Unson, MD
__ Patrick Burke, MD __ Sara Dobbs, MD __ Marjorie Alpert, MD __ Krista Amendola, MD

The following information is requested:

___ all of my medical records from (specify dates): _____

___ consultation reports from (specify dates): _____

___ laboratory results, radiology results, _____

___shot records from (specify dates): _____

The reason for my request is:

transferring to another practice/physician
other: _____

*** **PLEASE SIGN THE REVERSE SIDE** ***
*** FORM MUST BE FILLED OUT COMPLETELY ***

*For the release of **specially-protected medical information** (e.g. federal- or state-assisted drug and/or alcohol abuse treatment records, and HIV test results), this box must be completed.*

I hereby authorize release to the listed recipient the following records concerning the patient designated on this form:

__ Drug/Alcohol Abuse Information
__ HIV Blood Test Results
__ Psychological/Psychiatric reports

Signature: _____ Date: ____/____/____
Printed Name: _____
Relationship to Patient (if patient is a minor): _____

This authorization shall become effective from the date of signing and shall remain in effect for one year from the date of signing.

I do not have to sign this authorization in order to receive treatment from South East Bay Pediatrics. This authorization can be revoked by the undersigned party at any time between now and disclosure of the information by the disclosing party. The revocation must be submitted in writing to the disclosing party, and the written revocation will be effective upon its receipt. Any information that has been transferred or disclosed after the date of this authorization, but before the date of revocation, will not be affected by the revocation.

California law prohibits the recipient from making further disclosure of your protected 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.

I authorize the release of information indicated on this form. I understand that I can receive copy of this form if requested.

Signature: _____ Date: ____/____/____
Printed Name: _____
Relationship to Patient (if patient is a minor): _____

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