RECORDS RELEASE AUTHORIZATION

HOSPITAL DRIVE PEDIATRICS

2500 Hospital Drive #12
Mountain View, CA 94040
Phone (650) 968-1605
Fax (650) 968-4542

Primary MD: ☐ Monica Kenney, M.D. ☐ Patty P. Sabey, M.D. ☐ Kimberly Trujillo, M.D.

Patient Name: ______________________________ **Date of Birth**: _______________

Medical Record # (if known): _______________

☐ I Authorize Hospital Drive Pediatrics **To Release Information To**:	**OR**	☐ I Authorize Hospital Drive Pediatrics **To Obtain Information From**:
______________________________ Name of Provider or Facility		______________________________ Name of Provider or Facility
______________________________ Address		______________________________ Address
______________________________ City, State, Zip Code		______________________________ City, State, Zip Code
( )________________ Phone ( )________________ Fax		( )________________ Phone ( )________________ Fax

Description of information being disclosed:

☐ Copy of entire medical record as allowable by law

☐ All records related to a specific illness/injury ______________________________ (Dates _____________)

☐ Limited Health Record (Dates _____________)

☐ Radiology Reports ☐ Laboratory Tests ☐ Consultation Reports ☐ Immunizations

☐ Hospital Record ☐ Emergency Department Record ☐ Physical/Speech/Occupational Therapy

☐ School Records/IEP/Educational Testing ☐ Mental Health ☐ Other: _________________________

Purpose of the Disclosure: ☐ Update My Primary Physician ☐ Transfer of Care ☐ Other_______________

I understand that:

- The Patient's right to healthcare treatment is not conditioned on this authorization.
- This authorization is voluntary and I may refuse to sign it.
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- **Certain confidential information can be released only to the patient or another healthcare provider, but not to the patient's parent/guardian. Patients 18 years and older must request their own records.**
- I have the right to inspect or copy the health information to be used or disclosed pursuant to this authorization.
- There may be a charge for the requested records.

Signature: ______________________________________ Date: _______________

Print Name: ______________________________________ Relationship to Patient: _________________

Contact Number (_____) ___________________________

Expiration: ☐ 1 year from date of signature ☐ Upon release of the above records ☐ Until _______________

OFFICE USE ONLY: Received__________ MD reviewed__________Paid________ Released____________

Updated 8/25/2015