AUTHORIZATION FOR MEDICAL RECORDS RELEASE

Patient
Name:_____Birthdate:_____
Address:_____Phone Number:_____
City/State/Zip_____

I hereby authorize the physicians and/or employees of _____
ADDRESS_____
PHONE NUMBER_____
to release medical information as indicated below.

_____Hospital Reports
_____History & Physical Exam
_____Treatment Plans
_____Progress Notes
_____ALL MEDICAL RECORDS

____Lab/X-Ray Reports
____Medication Reports
____Consultation Reports
____Immunizations Records

PLEASE SEND RECORDS TO: CONEJO CHILDREN'S MEDICAL GROUP
558 N. VENTU PARK RD., #D
NEWBURY PARK, CA 91320
(805) 499-5525, Fax (805) 499-5554

THIS AUTHORIZATION IS EFFECTIVE IMMEDIATELY AND IS SUBJECT TO REVOCATION AT ANY TIME.
THIS AUTHORIZATION EXPIRES 90 DAYS FROM THE DATE OF SIGNING.

I further release my attending physician, consultants, the facility, and the employees from any liability arising from the release of information to the person (s)/agency designated above.

_____ Date

_____ Signature of Patient or Patient's Representative

_____ Relationship of Patient Representative to Patient