

AUTHORIZATION FOR MEDICAL RECORDS RELEASE

Patient

Name: _____ Birthdate: _____

Address: _____ Phone Number: _____

City/State/Zip _____

I hereby authorize the physicians and/or employees of Conejo Children's Medical Group to release medical information as indicated below.

____ Hospital Reports

____ Lab/X-Ray Reports

____ History & Physical Exam

____ Medication Reports

____ Treatment Plans

____ Consultation Reports

____ Progress Notes

____ Immunizations Records

____ ALL MEDICAL RECORDS

Release medical information to:

Name of Receiving Party

Address

City, State, Zip Code

PHONE NUMBER: _____

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