15290 Summit Avenue, Suite B
Fontana, CA 92336
Tel: (909) 225-1900 Fax: (909) 663-9072

Authorization for Release of Medical Information

Patient Name: ____ DOB: ___/___/_____

I, ____ hereby authorize the release of medical information TO:

Goldstar Pediatrics
15290 Summit Avenue, Suite B, Fontana CA 92336
Tel: (909) 225-1900 - Fax: (909) 663-9072

FROM:

Doctor/Clinic/Hospital: ____
Address: ____
____
____
Telephone Number: ____
Fax Number: ____

Please release the following:
___ All health information (including growth charts and vaccination records)

___ History/Physical Exam
___ Progress Notes
___ Discharge Summary
___ Consultation Reports
___ Diagnostic Test Reports
___ Radiology/Images
___ Lab Results
___ Pathology Reports
___Other (specify): ____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance abuse ________________(initial)
Psychiatric/Mental Health ________________(initial)
Tests for antibodies to HIV ________________(initial)
HIV Diagnosis and Treatment ________________(initial)
Genetic Information ________________(initial)

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Patient Name: ____ DOB: ___/___/_____

Purpose of disclosure:
__ Treatment/ Continuing medical care

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid for 1 year from the day on which it is signed.

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

Signature: ______________________________________Date: ___/___/__________

Print Name: ____

Relationship to Patient: ____

Witness Name: ______________________ Witness Signature: __________________