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)

Rev 04/07/2016

goldstar pediatrics

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Patient Name: _____ DOB: ___/___/_____

Purpose of disclosure:
___ Treatment/ Ongoing medical care
___ Coordination of 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 or facsimile of this authorization shall be considered as effective as 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: _____

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