Pediatric & Adult Medicine, Inc.

18102 Irvine Blvd. #103
Tustin, CA 92780-3423
Phone (714) 565-7960 - Fax (714) 565-7982

Authorization for Disclosure of Protected Health Information

(Records Release)

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed.

Patient Name: ______________________ DOB: ______________

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Patient Name: ______________________ DOB: ______________

I hereby authorize Pediatric & Adult Medicine

☐ **To Receive Records from:** **or** ☐ **To Release Records To:**

Name ______________________________________

Address: ______________________________________

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Please check the Reason for Release: ☐ Moving out of the area ☐ Change of Insurance

☐ Transfer of Care ☐ Personal Use

☐ Would you like our Office Manager to contact you regarding your reason for leaving our practice?

I specifically authorize the release of only the following information:

- ☐ All medical records
- ☐ Immunization information, problem list, and growth chart
- ☐ Lab results & X-ray results
- ☐ The portion of the records concerning: ______________________
- ☐ Other ______________________________

I understand that this authorization will automatically expire upon execution.
I authorize the release of information as indicated above.
I understand that there may be a charge for copying the records and processing this records release.

______________________________________ ______________
Signature of Patient / Parent / Legal Guardian Date

____
Printed Name