Pacific Coast Pediatrics

260 San Jose Street, Salinas CA 93901
Phone 831-757-8124 Fax 831-757-3954

# Authorization for Disclosure of Protected Health Information

Authorization for the disclosure of complete medical records will result in the release and disclosure of all information contained within the patient's electronic medical record. The release and disclosure will include mental health records, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below:

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**Authorization to disclose information:**

**Releasing to:** Name:______________________________________________________________

Address: ___________________________City: _____________________ State: _____ Zip: _______________

Phone: _______________________ Fax: _____________________ Email address: ______________________________

**Releasing from:** ***Pacific Coast Pediatrics***, 260 San Jose Street, Salinas, CA 93901

**Please mark one:**

☐ **Call when ready** ☐ **Mail when ready to above address** ☐ **Email (only a few pages)** ☐ **Fax to:** __________________

☐ **Mail to:** If address is different than above – Address: __________________________________________________________

**Please disclose the following information:**

☐ Complete chart ☐ Lab reports ☐ Operative reports ☐ X-ray reports ☐ Immunizations

☐ Certain dates of service? ___/___/___ ___/___/___ ___/___/___

☐ Other as specified: ________________________________________________________________________________

**Purpose of Disclosure:**

☐ Transfer of care due to a family move ☐ Transfer of care, other reasons: ____________________________________

☐ Consultation ☐ Insurance ☐ Other (please specify): ___________________________________________

**Acknowledgement:** By my signature below I declare that I am the patient, parent or legal guardian of the patient(s) listed below. I further acknowledge that I have personally read and completed the information above, agreeing to the specified authorization to release the medical records. In addition, I acknowledge that I understand the information which is disclosed under this authorization may be disclosed again by the person or organization to which it is sent and that the responsibility of privacy and security under the HIPAA act is transferred to the person(s) receiving this disclosure. I further understand that these records may indicate treatment for a psychiatric condition, alcohol or substance abuse and/or HIV testing and results.

This Authorization will remain in effect for 6 months from the signature date below unless revoked or terminated in writing by the patient, parent or legal guardian. For termination prior to 6 months, please call the office and request our HIPAA Compliance Officer.

*** Please allow 7-10 working days for completion of copying medical records. ***

Patient Name (print) : _______________________________________________________ Date of Birth: ___ / ___ / ___

Patient Name (print) : _______________________________________________________ Date of Birth: ___ / ___ / ___

**Name of parent or legal guardian (Please Print):** ________________________________________ Date: ___ / ___ / ___

**Signature of patient (if over 18 yrs.), Parent or legal guardian:** ______________________________________________