



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:

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 Fax to: _____

Email via secure mail (only a few pages @ no charge) Mail to a different address: _____

Please disclose the following information: Complete chart (provided on a usb drive, charges apply)

Lab reports Immunization X-ray reports Other, please specify: _____

Purpose of Disclosure: Transfer of care due to a family move Consultation Insurance

Other (please specify): _____

NOTE: A cost-based fee, due with this request, will apply for copies of medical records. Please speak to a receptionist for the specific fees that may apply depending on the records requested.

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: ___ / ___ / ___

2nd 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: _____

Receptionist – Confirm charges discussed with patient/parent: USB or paper? _____ Amount _____ Initials _____