eastbaypediatrics

2999 Regent Street, Suite 325, Berkeley, CA 94705
96 Davis Road, Suite 2, Orinda, CA 94563
(925) 438-1100
www.eastbaypediatrics.com

Authorization for Disclosure of Patient Information

Patient Name:_____ DOB:_____
Address:_____
Main Contact Number:_____ Receives Texts: Y___ N___
I hereby authorize _____, _____
(Facility/Provider Name) (Facility/Provider Address)

to release information from the medical record of _____
(Patient Name)

The following information may be released:

- ☐ Entire Medical Record ($30, due prior to processing)
- ☐ Summary of Records (Includes immunizations, growth charts, and last well visit. This information is also available on the patient portal)
- ☐ Records Between the Dates of: _____ & _____
- ☐ Newborn Discharge Summary
- ☐ Newborn Screening Record
- ☐ Other
  Please Specify (REQUIRED): _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE/FEDERAL LAW:
I hereby authorize the release of the following specific records and information:

- ☐ HIV/AIDS Related Testing
- ☐ Mental Health Related Records
- ☐ Chemical Dependency (Drug/Alcohol)

This information may be disclosed to and used by the following individual/organization:
Name: _____
Address: _____
Telephone Number: _____ Fax Number: _____

Reason for Release:

- ☐ Legal
- ☐ Moving out of area
- ☐ Insurance
- ☐ New Pediatrician
- ☐ Other (please specify)

_____

This authorization will remain in effect for 1 year from the date signed or until _____, whichever is shorter. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records Department. I understand the revocation will not apply to information that has already been released. I understand that with this authorization after leaving East Bay Pediatrics any outstanding balances will be paid in full within 30 days from the date signed.

_____ _____ _____
Signature of Patient/Legal Guardian Relationship to patient Date