AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Completion of this document authorizes use of individually identifiable protected health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this Authorization.

I hereby authorize ______________________________
Name of Disclosing Party

____
Address

____
City State ZIP

To disclose to **East Bay Pediatric Primary Care, Inc.**
2324 Santa Rita Road, Suite 12
Pleasanton, CA 94566
Phone: (925) 462-7700

Records and information pertaining to

______________________________ ______________
Name of Patient Date of Birth

______________________________ ______________
Address Telephone number

INFORMATION TO BE RELEASED:

____ All Medical Records

____ Birth Records	____ Lab / X-ray / Diagnostic studies
____ History & Physical exam(s)	____ Consultation / Surgical Reports
____ Progress Notes	____ Hospital Discharge Summary
____ Immunization Records	____ ER / Urgent Care Reports
____ Treatment Plans / Medication Records	____ Others (specify)

NOTICE OF RIGHTS AND OTHER INFORMATION

This authorization is effective immediately and can be revoked at any time, except to the extent that action has already been taken. Each request for release of information requires a separate authorization for use or disclosure. I realize this is a required consent and I must voluntarily and knowingly sign authorization before any records can be released. I may refuse to sign, but in that event, the records cannot and will not be released. I understand that this document will expire 6 months after the date below unless otherwise specified.

Protected Health information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by Federal confidentiality law (HIPAA). However, California law prohibits the person receiving my protected health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or is specifically permitted by law.

I further release my attending physician(s), East Bay Pediatric Primary Care, Inc. and their employees from any liability arising from the release of information as designated above.

______________________________ ______________
Signature of Parent or Authorized Representative Date

______________________________ ______________
Print Name Relationship to Patient