California Pediatrics
Come grow with us

Release of Medical Information

Patient Name *Nombre del Paciente*				
Date of Birth *Fecha de Nacimiento*		Gender *Genero*	Male *Masculino*	Female *Femenino*

Address *Domicilio*		Zip Code *Codigo Postal*	
Home Phone *Telefono de Casa*			
Cell Phone *Numero de Celular*			

I hereby authorize the release of my child's information:

- □ Medical Record
- □ Immunization Record
- □ Lab Results/Xray Reports
- □ Other

From:

To:

California Pediatrics

1595 Grand Avenue Suite 102 San Marcos, CA 92078

Office (760) 798-0428

Fax (760) 798-9618

- I understand that the information in my child's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authroization, I must do so in writing and present my written and signed revocation to *California Pediatrics* . I understand that the revocation will not apply to my insurance company when the law provides the insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire when the patient is eighteen years of age.

Name *Nombre*		Relationship *Relacion al Paciente*	
Signature *Firma*		Date *Fecha*	