MEDICAL RECORD RELEASE AUTHORIZATION FORM

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. *Note: information regarding treatment of minors, HIV, Psychiatric/mental health conditions, or alcohol/substance abuse has special rules that require specific authorization.*

Patient Name: _____ DOB: _____/_____/_____

_____

Patient Address

_____

City State Zip

I hereby authorize: (Please mark next to the physicians name you are requesting from)

___ Laura Bruckner, M.D. ___ Andrew Krasnoff, M.D. ___ Helen Lederer, M.D.

___Catherine Marshall, M.D. ___ Sloane Sevran, M.D. ___ Daniel Bruckner, M.D.

___ Miriam Chan, M.D. ___ Julia Bruckner, D.O. ___ Ofir Mekel, M.D.

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence, and/or medical records by mean of mail, fax, or other electronic methods.

Records will be released to:

_____

Name

_____

Address

_____(_____) _____-_____

City State Zip Code Phone Number

The medical information will be used for the following purpose:

[ ] Transfer Care to New Practice [ ] Specialist Review

[ ] Insurance Review [ ] Other:_____

Send request via:

[ ] Fax (_____) _____-_____

[ ] Email: _____

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5400 Balboa Blvd Ste 326
Encino, CA 91316
818-789-8775

MEDICAL RECORD RELEASE
AUTHORIZATION FORM

This authorization is for:

[ ] **All Records** (excluding substance abuse, mental health, HIV Diagnosis/Treatment)
[ ] Limited to the following medical information: _____

I also consent to the specific release of the following records:

[ ] Drug/Alcohol/Substance Abuse [ ] Tests for Antibodies to HIV
[ ] Psychiatric/Mental Health [ ] HIV Diagnosis/Treatment

Duration: This authorization is effective from _____ until _____.

Restrictions: Permissions of further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy, e-mail, or facsimile of this authorization shall be considered as effective and valid as the original.

E-Mail: MedicalRecords@BalboaPediatrics.com

Fax: 818-789-6726

_____
Signature of Patient/Legal Representative

_____
Relationship to patient

_____
Date

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Encino, CA 91316
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