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:

_____

Name

_____

Address

_____

City State Zip Code

(_____) _____-_____ (_____) _____-_____

Phone Number Fax Number

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:

___ 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.

Send request via:

Fax: 818-789-6726
E-Mail: MedicalRecords@BalboaPediatrics.com

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

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

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The medical information will be used for the following purpose:

[ ] Dr. Review [ ] Insurance Review [ ] Other:_____

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.

_____
Signature of Patient/Legal Representative

_____
Relationship to patient

_____
Date

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