

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.
___ Irwin Bruckner, M.D. ___ Catherine Marshall, M.D. ___ Sloane Sevrans, M.D.
___ Daniel Bruckner, M.D. ___ Miriam Chan, M.D. ___ Julia Bruckner, D.O.

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.

Continue on back page →

MEDICAL RECORD RELEASE AUTHORIZATION FORM

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