

# MEDICAL RECORD REQUEST 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:**

<input type="checkbox"/> Laura Bruckner, M.D.	<input type="checkbox"/> Andrew Krasnoff, M.D.	<input type="checkbox"/> Helen Lederer, M.D.
<input type="checkbox"/> Irwin Bruckner, M.D.	<input type="checkbox"/> Catherine Marshall, M.D.	<input type="checkbox"/> Sloane Sevrans, M.D.
<input type="checkbox"/> Daniel Bruckner, M.D.	<input type="checkbox"/> Miriam Chan, M.D.	<input type="checkbox"/> Julia Bruckner, D.O.

**Send request via:**

[ ] Fax (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

[ ] Email: \_\_\_\_\_

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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.

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

E-Mail: [MedicalRecords@BalboaPediatrics.com](mailto:MedicalRecords@BalboaPediatrics.com)

Fax: 818-789-6726

\_\_\_\_\_  
Signature of Patient/Legal Representative

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Date