SANG PEDIATRICS

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Medical Release Form

Patient Name:_____ Date of Birth:____/____/_____

1. I authorize the use of disclosure of the above named individual's health information as described below.
2. The following individual or organization have my permission to make the disclosure:

Name: _____ Tel. _____
Address:_____ Fax._____
_____

3. The type and amount of information to be used or disclosed is as follows (include dates where appropriate):

___ Entire Records
___ Immunization Record
___ Medication
___ Problem List
___ List of Allergies
___ Most Recent Discharge Summary
___ Most Recent History and Physical
___ Laboratory Results from (date) _____ to (date) _____
___ X-ray and Imaging Reports from (date) _____ to (date) _____
___ Consultation Reports from (Doctor's Name) _____
___ Other _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, required 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.

5. This information may be disclosed to and used by the following organization:

To: Sang Pediatrics Tel. (559) 268-1737
Address: 1122 S Street, Suite 102 Fax (559) 268-1738
Fresno, CA 93711

For the purpose of: _____

6. I understand that I have the right to revoke this authorization at any time. I understand if I revoke the authorization I must do so in writing and present my written to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition for (years) _____.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need to sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with its potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact (insert HIM director, privacy officer, or other office or individual's name or contact information).

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

Form Faxed on: _____ By: _____