AUTHORIZATION FOR MEDICAL RECORDS RELEASE

Patient Name____________________________ Birth date_________________

Doctor Office information
Name ____
Address____
Phone #____
Fax # ____

Patient treated from ______________ (date) to ______________ (date)

Information to be released:
____ Hospital reports
____ History & Physical Exam
____ Treatment plans
____ Progress Notes
____ Lab/ X-ray reports
____ Medication report
____ Consultation reports
____ VACCINATION RECORDS
____ ALL MEDICAL RECORDS

Other (please specify): ____

I understand that this is a required consent and that I must voluntarily and knowingly sign this authorization BEFORE any records can be released, and that I may refuse to sign.

I further release my attending physician, consultants, the facility, and the employees from any liability arising from the release of information to the person designated above. I understand that I have the right to receive a copy of this authorization upon my request.

Signature of Patient ____________________________________ Date_______________

Signature of Parent/Guardian_____________________________ Date_______________

Relationship to Patient___________________________________

Please send records to:

OAK PARK PEDIATRICS
Andrew M. Matthew, M.D. Jessica M. Hochman, M.D.

358 N. Kanan Road
Oak Park CA, 91377

818-707-0046
Fax: 818-707-2430