NOE VALLEY PEDIATRICS

AUTHORIZATION FOR THE RELEASE OF MEDICAL NFORMATION

3700 24th Street, San Francisco, CA. 94114
Telephone: 415-641-1019 * Fax: 415-826-1308

PATIENT NAME:_____
Last Name First Name M.I.

DATE OF BIRTH:_____/_____/_____ MR#_____

I authorize: ◯ **NOE VALLEY PEDIATRICS**
◯ **Other:**_____
Facility/Hospital/Organization releasing information

To release/disclose health information to:

_____
Facility receiving information

_____
Mailing Address

_____
City State Zip Code

As one-time courtesy, Noe Valley Pediatrics will forward all growth charts, immunization records, and a medication and health summary free of charge to the new provider. All subsequent requests will incur a $50 charge.

The purpose of this Release is for (Check all that apply)

- ☐ Medical Care
- ☐ Insurance
- ☐ Legal Claim
- ☐ Patient/Personal
- ☐ Other (List)_____

Information requested (check all that apply):

☐ Pertinent Summary (discharge summary, history and physical, operative, pathology, consultation, radiology, reports, labs and EEGs)
☐ Emergency Record ☐ Clinic Records ☐ Immunizations ☐ Other_____

Date(s) of Treatment ☐ From _____ to _____ ☐ All dates of service

The following information WILL NOT BE RELEASED unless you specifically authorize it by checking the appropriate box(es) below.

- ☐ Drug/alcohol diagnosis or treatment information
- ☐ Mental health diagnosis or treatment information
- ☐ Reproductive health including pregnancy and sexually transmitted disease, HIV/AIDS status.
- ☐ Genetic testing information

Expiration of Authorization

Unless otherwise revoked, this authorization expires on _____ or 12 months after the date of my signing this form. I understand:

- This authorization may be revoked in writing at any tie except t the extent that NVP has already disclosed the information.
- If disclosure of this health information is to someone who is not legally required to keep it confidential, it may be redisclosed and my no longer be protected.
- I have the right to receive a copy of this authorization.

I understand that once the records are released my child is NO LONGER A PATIENT of Noe Valley Pediatrics. Re admittance to the practice will be contingent on approval from the doctor.

_____
Signature Date Area Code and Phone number

_____
Address