NOE VALLEY
PEDIATRICS

AUTHORIZATION TO RELEASE MEDICAL RECORDS TO NOE VALLEY PEDIATRICS

Patient Name: _____ **Date of Birth**: _____

Street Address: _____

City/State/Zip: _____

Contact Phone Number: _____

I hereby authorize:

Facility Name: _____ Facility phone: _____

Facility Address: _____ Facility Fax: _____

City/State/Zip: _____

To disclose medical records to:

Noe Valley Pediatrics
3700 24th St.
San Francisco, CA 94114
Phone: (415) 641-1019
Fax: (415) 826-1308

Types of information to disclose (check all that apply):

- ☐ All Health Care Information in My Medical Record
- ☐ Mental Health Information
- ☐ Drug and/or Alcohol Information
- ☐ Sexually Transmitted Disease Information
- ☐ Other Information: _____

This authorization shall become effective immediately and shall remain in effect until revoked in writing by the patient.

SIGNATURE:

_____ _____
Signature of Patient/Parent/Guardian or Authorized Representative Date

_____ _____
Printed Name of Authorized Representative Relationship to patient