NOE VALLEY PEDIATRICS

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

AUTHORIZATION TO RELEASE MEDICAL RECORDS FROM NOE VALLEY PEDIATRICS

Patient Name: _____ Date of Birth: _____

Street Address: _____ Contact Phone: _____

City/ State/ Zip Code: _____

I hereby authorize Noe Valley Pediatrics to release/ disclose health information to:

Facility Name: _____ Facility Phone: _____

Facility Address: _____ Facility Fax: _____

City/ State/ Zip Code: _____ Facility Email: _____

Purpose of release (check all that apply):

☐ Transfer of Care (see agreement below) ☐ Coordination of care with specialist

☐ Patient / Personal Request ☐ Legal ☐ Insurance ☐ Other: _____

Information Requested (check all that apply):

☐ Transfer of care records: Last 3 well checks, growth charts, and immunization record

☐ Other - please specify type information you would like disclosed, including dates of care if necessary:

_____

_____

The following will **NOT BE RELEASED** unless you specifically authorize it by checking the appropriate boxes 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

Authorization Agreement:

- Unless otherwise revoked, this authorization expires in 12 months after the date of my signing this form.
- This authorization may be revoked in writing at anytime to 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 no longer be protected.
- I have the right to receive a copy of this authorization.
- **I understand that once transfer of care 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:

_____ _____

Signature of Patient/Parent/Guardian Date

_____ _____

Printed Name of Patient/Parent/Guardian/ Authorized Representative Relationship to Patient