

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize Bay Area Pediatric Pulmonary to: Release Obtain information regarding
the treatment of _____ Birth date _____
(Print Patient's Full Name)

- Release information to:
- Obtain information from:

(Name of Physician, Hospital, Clinic)

(Street)

(City) (State) (Zip code)

Date(s) of Service _____

Please Provide the Following Information:

- | | |
|---------------------------|--------------------------|
| ___ History/Physical Exam | ___ Laboratory Reports |
| ___ Discharge Summary | ___ Consultation Reports |
| ___ Progress Notes | ___ Operation Reports |
| ___ Radiology Reports | ___ Pathology Reports |
| ___ Other: _____ | |

(Signature of Patient / Parent / Guardian)

(Street)

(City) (State) (Zip code)

(Telephone Number)

This authorization is valid for one year from the date indicated below unless otherwise specified.

Date _____ Witnessed by _____

The authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Section 56, California Civil Code.