

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
(FROM ANOTHER FACILITY TO EL CAMINO PEDIATRICS)**

Patient Name _____ Birth Date _____

Patient Address _____

I authorize the release of Health Information **FROM:**

(Name of person or facility to receive health information)

(Specify name/title of person to receive health information, if known)

(Street Address, City, State, Zip Code)

TO:

El Camino Pediatrics Medical Group, Inc.
Drs. Frumin, Dockweiler, Gross, Levy, Wood, Bhasin, Snyder-Block, Reinhardt, Rubin, Taylor, Dern and Gillin
477 N. El Camino Real, Suite B105, Encinitas, CA 92024
Phone: 760-753-7143 Fax: 760-753-2155

INFORMATION TO BE RELEASED:

<input type="checkbox"/> Birth History	<input type="checkbox"/> Growth Charts	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> History and Physical Exams
<input type="checkbox"/> Lab Reports	<input type="checkbox"/> Hospital Reports	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Consultations/Evaluations
<input type="checkbox"/> Allergies	<input type="checkbox"/> ER visits	<input type="checkbox"/> Mental Health Reports	<input type="checkbox"/> Diagnostic Tests (EKG, Xrays, EEG, etc.)
<input type="checkbox"/> Other _____			

SPECIFY THE DATE OR TIME PERIOD FOR INFORMATION SELECTED ABOVE _____

I wish to **EXCLUDE** _____ medical information from being released.

THE PURPOSE OF THIS RELEASE IS: (check one or more)

- At the request of the patient/patient representative
- Other _____

NOTICE

1. I have the right to revoke this authorization in writing and submit to _____ (name of facility releasing Health Information), unless the Health Information has already been released. The revocation will take effect when it is received.
2. I understand this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be a condition to release Health Information except as allowed by federal and/or state law.
3. El Camino Pediatrics will maintain confidentiality of our patient's Health Information as mandated by state and federal confidentiality laws. If you have authorized the disclosure of your Health Information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.
4. I have a right to receive a copy of this authorization.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this authorization expires on _____ (insert applicable date or event; if no date is indicated, this authorization will expire 12 months after the date of signing this form)

SIGNATURE

(Signature of Patient or Patient's Legal Representative)

Date: _____

(Printed Name)

(If signed by someone other than patient, state relationship to patient)