

Bakersfield Pediatrics

300 Old River Rd. Ste. #105 Bakersfield, Ca. 93311
P (661) 663-4700 F (661) 663-4740 & (661)-663-4711
1215 34TH Street Bakersfield, Ca 93301
P (661) 663-4700 F (661) 489-3338
Email: info@bakersfield-pediatrics.com

This authorization is for Bakersfield Pediatrics to release or receive information that is being requested of you to comply with the terms of the Confidentiality of Medical Information Act, Section 56 of CA. Civil Code.

CHILD'S NAME _____ D.O.B ___/___/___ CHILD'S NAME _____ D.O.B ___/___/___
CHILD'S NAME _____ D.O.B ___/___/___ CHILD'S NAME _____ D.O.B ___/___/___
DAYTIME TELEPHONE NUMBER () _____ - _____

I HEREBY AUTHORIZE RECORDS RELEASED FROM: Parent or Medical Office (circle one)

(Name of person or organization receiving information)

Street Address

City

State

Zip Code

Phone

Fax

RELEASE RECORD INFORMATION TO: PLEASE CIRCLE ONE

Bakersfield Pediatrics

300 OLD RIVER RD # 105
BAKERSFIELD, CA 93311
(P) 661-663-4700 (F) 661-663-4711

OR

1215 34th STREET
BAKERSFIELD, CA 93301
(P) 661-663-4700 (F) 489-3338

THIS RELEASE LIMITS DISCLOSURE TO:

ALL RECORDS Lab X-Ray Reports Immunizations
 X-ray films required: _____ Other: _____

Information not to be released, if any: _____

A specific authorization is required to release information regarding the following: (please initial the columns if this information is to be included)

	YES	NO	INITIALS
HIV Information	_____	_____	_____
Drug/Alcohol Information	_____	_____	_____
Mental Health Information	_____	_____	_____

This information is required for:

Second Opinion Referral Residence Relocation Insurance Change
 Dissatisfaction with Dr /Practitioner./Staff (Please Specify): _____
 Other (please specify): _____

This authorization shall be valid until _____. Please indicate a date after which no information can be released. If no date is given, consent will be valid for 90 days only.

I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, IN WRITING, BEFORE THE INFORMATION HAS BEEN RELEASED. I FURTHER UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION UPON REQUEST.

PARENT/GUARDIAN/ AUTHORIZED REPRESENTATIVE (Print) _____ DATE ___/___/___

PARENT/GUARDIAN/ AUTHORIZED REPRESENTATIVE (Signature) _____ DATE ___/___/___