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____/____/_____