Bakersfield Pediatrics

300 Old River Rd. Ste. #105 Bakersfield, Ca. 93311
P (661) 663-4700 F (661) 663-4740
Email: info@bakersfield-pediatrics.com

This authorization is for Dr. Bustamante 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:

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

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____/____/_____