## Coastal Pediatric Medical Group, Inc.

Oxnard, CA Phone 805 983-3900 Fax 805 983-3887 Ventura, CA Phone 805 643-9271 Fax 805 643-6717

## AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.* 

| AUTHORIZATION  I hereby authorize:   |                           |   |   |   |                   |  |
|--|---------------------------|---|---|---|-------------------|--|
| (Name & address of physician or medical group)   |                           |   |   |   |                   |  |
| To release information reg diagnosis or prognosis, incother electronic methods.  |                           |   |   |   |                   |  |
| To: Coastal Pediatric  | Medical Group, Inc.       | 1                                       |   |   |                   |  |
| Name<br><b>451 W. Gonzale</b> s  | Pond                      |   |   |   |                   |  |
| Address  | Road                      |   |   | *************************************** |                   |  |
| Oxnard   | California                | 93036                                   |   |   |                   |  |
| City   | State                     | Zip                                     |   |   |                   |  |
| The medical information/re   | cords will be used for t  | the following pu                        | ırpose:   |   |                   |  |
| This authorization is: ( ) Unlimited (all records,   | excluding Substance At    | ouse, Mental He                         | ealth, HIV Dia  | ignosis/Treatment)                      |                   |  |
| ( ) Limited to the following   | g medical information:    |   |   |   |                   |  |
| I also consent to the sp   | ecific release of the     | following rec                           | ords:   |   |                   |  |
| Drug/Alcohol/Substance Abuse (initial) Psychiatric/Mental Health (initial) Parents Medical History (initial)   |                           |   | Tests for Antibodies to HIV (initial) HIV Diagnosis/Treatment (initial) |   |                   |  |
| <b>DURATION</b> This authorize   | zation shall be effective | e immediately a                         | nd remain in  | effect until                            |                   |  |
| Anticological and an anticological and anticological and anticological and anticological and anticological anticological and anticological and anticological and anticological anticological anticological and anticological anticologica |                           | ,                                       |   | Dat                                     |                   |  |
| <b>RESTRICTIONS</b> Permis another authorization is oblaw.   |                           |   |   | _                                       |                   |  |
| A photocopy of facsimile of  | this authorization shall  | l be considered                         | as effective  | and valid as the origir                 | nal.              |  |
| I have been advised of my  | right to receive a copy   | of this authoriz                        | zation  |   |                   |  |
| Patient's Name (please print)  |                           | Date                                    | of birth  | Date                                    | WARRANTON BOLLMAN |  |
| Signature of patient or legal re   | epresentative             | *************************************** | Relationship  | (if other than patient)                 |                   |  |
| Witness  | -                         |   |   |   |                   |  |

## Coastal Pediatric Medical Group, Inc.

Oxnard, CA Phone 805 983-3900 Fax 805 983-3887 Ventura, CA Phone 805 643-9271 Fax 805 643-6717

## AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.* 

| AUTHORIZATION  I hereby authorize: |   |                            |  |   |  |  |
|------------------------------------|---|----------------------------|--|---|--|--|
| Tilei                              |   | Name & address of physic   | cian or medical group)   | <del></del>   |  |  |
| diagn                              |   |                            | ory, illness or injury, consulta<br>ndence and/or medical record   | tions, prescriptions, treatments ds by means of mail, fax or      |  |  |
| То:                                | 70 min  | Medical Group, Inc.        |  | <del>_</del>  |  |  |
|                                    | Name<br>100 N. Brent Stre   | et, Ste 102                |  |   |  |  |
|                                    | Address   |                            |  |   |  |  |
|                                    | City  | <u>California</u><br>State | <b>93003</b>   |   |  |  |
| The n                              | •   | cords will be used for t   | he following purpose:  |   |  |  |
|                                    | authorization is:   | cords viii be doca for a   | The following purposes   |   |  |  |
|                                    |   | excluding Substance Ab     | ouse, Mental Health, HIV Diag                                      | gnosis/Treatment)   |  |  |
| ( ) Li                             | imited to the following   | g medical information:     |  |   |  |  |
| I also                             | o consent to the sp   | ecific release of the f    | following records:   |   |  |  |
| Psych                              | /Alcohol/Substance Al<br>niatric/Mental Health<br>nts Medical History | (initial)                  |  | tibodies to HIV (initial) sis/Treatment (initial)                 |  |  |
| DUR                                | ATION This authori  | zation shall be effective  | immediately and remain in e  | effect until  |  |  |
|                                    |   |                            | disclosure of this medical info<br>ss such disclosure is specifica | Date ormation is not granted unless ally required or permitted by |  |  |
| A pho                              | otocopy of facsimile o  | this authorization shall   | be considered as effective a                                       | and valid as the original.  |  |  |
| I have                             | e been advised of my  | right to receive a copy    | of this authorization  |   |  |  |
| Patien                             | t's Name (please print)   |                            | Date of birth  | Date  |  |  |
| Signat                             | ture of patient or legal r  | epresentative              | Relationship   | (if other than patient)   |  |  |
| Witnes                             | <br>SS  |                            | <del></del>  |   |  |  |