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: **Coastal Pediatric Medical Group, Inc.**

(Name & address of physician or medical group)

451 W. Gonzales Road, Ste 340 Oxnard, CA 93036

To release information regarding my medical history, illness or injury, consultations, prescriptions, treatments, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic methods.

To: _____

Name

_____

Address

_____

City State Zip

The medical information/records will be used for the following purpose: _____

This authorization is:

( ) Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

( ) Limited to the following medical information:

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____ (initial)
Psychiatric/Mental Health _____ (initial)
Parents Medical History _____ (initial)

Tests for Antibodies to HIV _____ (initial)
HIV Diagnosis/Treatment _____ (initial)

DURATION This authorization shall be effective immediately and remain in effect until _____

Date

RESTRICTIONS Permission for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization

_____ _____ _____

Patient's Name (please print) Date of birth Date

_____ _____

Signature of patient or legal representative Relationship (if other than patient)

_____

Witness

Coastal Pediatric Medical Group, Inc.

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I hereby authorize: **Coastal Pediatric Medical Group, Inc.**

(Name & address of physician or medical group)

100 N. Brent Street, Ste 102 Ventura, CA 93003

To release information regarding my medical history, illness or injury, consultations, prescriptions, treatments, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic methods.

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