

# Golden Gate Pediatrics - A Medical Corporation

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## Authorization for Disclosure of Patient Information

Please provide all information requested or this Authorization is not valid. Please Print.

**\$25.00 record release fee - Check Enclosed**  **or** **Cash paid in person**  **or**  
**Credit Card Number (Visa/MasterCard)** \_\_\_\_\_ **exp. Date** \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: (\_\_\_\_\_) \_\_\_\_\_

I hereby authorize \_\_\_\_\_  
(Facility/Provider Name and Location)

To Release information from the medical record of \_\_\_\_\_  
(Patient Name)

### **The following information:**

- All pertinent records
- Records from last \_\_\_\_ year(s), including progress notes, immunizations, lab & x-ray reports, & consult notes.
- Lab reports - date(s)
- X-Ray report(s)
- Progress Notes - date(s)
- Other (please specify) \_\_\_\_\_

### **For the following purpose:**

- Legal
- Insurance
- Patient Request
- Moving
- Other (please specify) \_\_\_\_\_

### **SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW**

I hereby specifically authorize the release of data and information relating to: (check any that apply)

- HIV / AIDS related testing
- Mental Health
- Chemical Dependency (Drug/Alcohol)

This information may be disclosed to and used by the following individual or organization:

Name: \_\_\_\_\_

Address : \_\_\_\_\_

Telephone Number: (\_\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_\_) \_\_\_\_\_

This authorization will be valid for 180 days from the date it is signed or until \_\_\_\_\_, whichever is shorter.

This authorization may be revoked at any time by notifying the above named provider of information in writing, except when this authorization was obtained as a condition of obtaining insurance coverage. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Information used and disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected.

\_\_\_\_\_  
Signature of Patient or Legal Guardian  
(Parent/Legal Guardian must sign if patient is a minor)

\_\_\_\_\_  
Relationship to Patient, if not the patient

Date: \_\_\_\_\_

### **Office Use Only**

Copied by: \_\_\_\_\_ Date: \_\_\_\_\_

To be sent

To be picked up  Date: \_\_\_\_\_

Sent on date: \_\_\_\_\_

Approved for release by PCP: \_\_\_\_\_