Medical Release Form

Patient First Name **Last Name** **Date of Birth**

Requested From:

Name of Provider **Provider Phone**

Address **Provider Fax**

City **State** **Zip**

Send Information To:

Robertson Pediatrics

150 N Robertson Blvd, Ste 307 Beverly Hills, CA, 90211

(Fax) 310-659-2420

(email) info@robertsonpediatrics.com

I authorize the release of the following health information:

☐ **All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.**

I authorize the release of my health information for the following specific purpose:

At the request of the patient's parent/guardian Other purpose

Other Purpose _____

I understand that this Authorization will remain in effect until: _____

Date of authorization expiration

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

I,_____ , authorize to release confidential health information about me. You may release a copy of my medical records, or a summary or narrative of my protected health information to .

_____ _____

Parent/Guardian Signature **Date**