CHILDREN'S MEDICAL GROUP OF ORANGE COUNTY

500 ANAHEIM HILLS ROAD, SUITE 110 ANAHEIM, CALIFORNIA 92807

1. I authorize (FROM)	2. To release to
Children's Medical Group	______________________ (name)
500 S Anaheim Hills Road, suite 110	______________________(address line 1)
Anaheim, CA 92807	______________________(address line 2)
Phone 714-282-2229	phone ________________
Fax 877-794-9299	fax ________________

3. **PATIENT'S NAME:**______________________________**DATE OF BIRTH:**______________

4. **INFORMATION TO BE RELEASED:** (Check all applicable)

☐ All Information ☐ All Progress Notes ☐ Lab Reports ☐ X-ray Reports
☐ Electrocardiogram (ECG) ☐ Allergy Records ☐ Immunization Records ☐ Other

SPECIAL AUTHORIZATION: Check applicable box (es) and sign immediately below.
By signing below, I am authorizing the office to release any and all information regarding:
☐ Alcohol ☐ Drugs ☐ Mental Health ☐ Sexually Transmitted Diseases ☐ HIV ☐ AIDS

Note: If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Signature: ____________________________________ Date: ________________________

5. **RECORDS FROM THE TIME PERIOD:** / / through / /

6. **PURPOSE OF DISCLOSURE:** (Check applicable purpose)

☐ Change of insurance ☐ Second opinion ☐ Legal
☐ Moving out of area ☐ Transfer of care ☐ Other:

7. I understand that this authorization shall be valid for one year. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

8. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

9. The requestor may be provided with a copy of this authorization.

Signature____________________Print Name ______________________ date__________

Parent must sign if patient is under 18 years of age

Patient must sign if over 18 years of age