TENTH STREET PEDIATRIC MEDICAL GROUP, INC.

1450 Tenth Street, Suite 304 * Santa Monica, CA 90401-2838
Phone (310) 458-1714 * Fax (310) 394-8754

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

☐ Dear Dr: _____

_____

_____

Please forward my child's/children's medical records to:

Tenth Street Pediatrics
1450 Tenth Street, #304
Santa Monica, CA 90401-2838

OR

☐ TO: Tenth Street Pediatrics

Please release my child's/children's medical records to:

Name: _____

Address: _____

_____

I understand that I have the right to limit the type of information released from my medical records, as in the case of HIV test results, mental health information, and alcohol and drug abuse information. The following information is to be released:

☐ *I have no limitations on the information to be released from my medical record including information concerning AIDS or results of HIV testing, psychological or psychiatric treatment, and/or alcohol or drug abuse.*

☐ *The information to be released from my medical records shall be limited to:*

_____

Child _____ Date of Birth _____

Child _____ Date of Birth _____

Child _____ Date of Birth _____

Child _____ Date of Birth _____

Print Name of Parent/Guardian _____ Date _____

Signature of Parent/Guardian _____ Phone (____) _____

The reason for my requesting that my medical records be copied is:

☐ Changed Insurance ☐ Second opinion ☐ Personal Use
☐ Changed Doctor ☐ Legal case ☐ Unhappy with care/service
☐ Moving out of area ☐ Accident/Third Party Liability ☐ Other_____