authorization by parent for MD to s... Open with... provider.pdf

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Lisa

TENTH STREET PEDIATRIC MEDICAL

1450 Tenth Street, Suite 304 * Santa Moni
Phone (310) 458-1714 * Fax (310

AUTHORIZATION FOR RELEASE OF IN

TO: Tenth Street Pediatrics

I hereby give my permission for Dr. _____
medical history with the following person/entit

Name: _____

Address: _____

_____

Phone: _____

Child _____

Print Name of
Parent/Guardian _____

Signature of
Parent/Guardian _____

I understand that I have the right to limit the type of information relea
the case of HIV test results, mental health information, and alcohol
following information is to be released:

☐ *I have no limitations on the information to be released fi*
information concerning AIDS or results of HIV t
treatment, and/or alcohol or drug abuse.

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

_____

_____

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