

Gmail

COMPOSE

Inbox (1,955)

Important

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Drafts (14)

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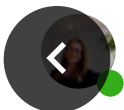
▶ Circles

[Gmail]Trash

Book group

Drlisatenthst@gmail.c...

Farlin house


Lisa
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TENTH STREET PEDIATRIC MEDICAL

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

AUTHORIZATION FOR RELEASE OF INFORMATION

TO: Tenth Street Pediatrics

I hereby give my permission for Dr. _____
to release my _____
medical history with the following person/entity:

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 released in the case of HIV test results, mental health information, and alcohol or drug abuse. The following information is to be released:

I have no limitations on the information to be released from my medical records concerning AIDS or results of HIV treatment, and/or alcohol or drug abuse.

The information to be released from my medical records shall be limited to _____

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