San Diego Internal Medicine
PEDIATRICS

OFFICE USE:	□ ID Checked
Recvd by:	
Date/Time:	
MRN:	
Completed by:	
Completed Date:	

If over 30 pages PLEASE mail us the records and no CDs please

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

NAME OF PATIENT: _____ **DOB:** _____ PHONE: _____

ADDRESS: _____ CITY_____ STATE: _____ ZIP CODE: _____

I hereby authorize the following entity to release my Protected Health Information (PHI):

NAME: _____ PHONE: _____ FAX: _____

ADDRESS: _____ CITY_____ STATE: _____ ZIP CODE: _____

Send records to the following entity or person:

NAME OF ENTITY/PERSON: _____ PHONE: _____ FAX: _____

ADDRESS: _____ CITY_____ STATE: _____ ZIP CODE: _____

INFORMATION REQUESTED: _____

DATES OF SERVICE: From: _____To: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

I authorize release of information of the following portions of my medical record:

□ Mental Health
□ Substance Abuse
□ HIV/AIDS
□ All
□ Communicable Disease

I understand that this information shall be in effect for 180 days following the date of signature. However, I understand that this authorization may be revoked at any time by giving oral or written notice to the medical office. A photocopy of this authorization shall constitute a valid authorization. I understand that once my medical records have been released, the medical office cannot retrieve them and has no control over the use of the already releases copies.

Should my case require review by a governing agency or another medical profession actively involved in my care to make a final determination, it is with my consent that a copy of these records will be submitted to the agency or medical profession for this review.

Signature of Patient (or legal representative) _____ **Date:** _____

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