



**Authorization for Use or Disclosure of Health Information**

I, the undersigned, authorize the release of, or request access to the confidential information and records regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, and/or correspondence, including those from my other healthcare providers that the below named health provider may hold, by means of mail, fax, or other electronic methods. I understand the potential for this information to be redisclosed by the recipient and therefore no longer protected by the federal privacy rule.

**AUTHORIZATION** I hereby authorize

To Release to:

\_\_\_\_\_  
Physician/Healthcare Facility/Patient/Parent

\_\_\_\_\_  
Address/State/City/Zip

\_\_\_\_\_  
Phone Number                      Fax Number

**Premier Pediatrics of Beverly Hills**  
8907 Wilshire Blvd Ste. 250  
Beverly Hills, CA 90212  
Phone: 310.247.8687 Fax: 310.859.9131

**TYPE OF RECORD REQUESTED:**

Complete Medical Record

Immunization Record Only

**PURPOSE OF REQUEST:**

At the request of patient/patient representative

Transferring to New Physician

Other: \_\_\_\_\_

**DATES OF SERVICE REQUESTED:** From: \_\_\_\_\_ To: \_\_\_\_\_

**State/Federal Laws require specific authorization to release the following types of authorization, I specifically authorize the release of:**

Mental Health

HIV test results

Alcohol/Drug Abuse

**A separate authorization is required for psychotherapy notes.**

This authorization is effective immediately and shall remain in effect until: \_\_\_MM/\_\_\_DD/\_\_\_YY

This document will automatically expire 12 months after the signed date.

I may revoke this request at any time. My cancellation will be effective when it has been received in writing by Premier Pediatrics Beverly Hills. My revocation must be signed and delivered to the address or fax number at the bottom of the page.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Date of Birth

\_\_\_\_\_  
Name of Parent/Legal Guardian (Print)

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Signature of Parent/Guardian/Patient (if over 18 years old)

\_\_\_\_\_  
Date