



BEVERLY HILLS PEDIATRICS

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct the health care provided named below,

BEVERLY HILLS PEDIATRICS
8530 Wilshire Blvd, Suite 520
Beverly Hills, CA 90211
Phone 310-854-0770
Fax 310-854-0440

to disclose my health information during the term of this authorization to the recipient that I have identified below:

Recipient and Address for delivery of records:

Name (physician, healthcare facility, insurance carrier, other)

Address

Phone Number

Fax Number

The medical information will be used for the following purpose:

_____ Transferring to a new physician

_____ Insurance Underwriting

_____ Specialist request

_____ Other, please explain _____

This authorization is:

_____ Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment; unless noted below)

Drug/Alcohol/Substance Abuse _____ (initial)

Test for Antibodies to HIV _____ (initial)

Psychiatric/Mental health _____ (initial)

HIV Diagnosis/Treatment _____ (initial)

_____ Limited to the following information: _____

Duration: This authorization will be effective immediately and remain in effect for 90 days.

Restrictions: Permission for further use of discloser of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization shall be considered as effective and valid as the original. I understand that I will be charged \$35.00 to copy my child's medical records. Immunization records only are available at no charge.

I have been advised of my right to receive a copy of this authorization:

Signature of patient or legal/personal representative

Relationship to patient

Patient Name (print)

Patient Date of Birth

Witness Name (print)

Witness Signature