Consent to Release of Medical Records

I, ____ hereby authorize Irvine Doctors of Kids and Teens, its agents, or employees to disclose Protected Health Information contained in my or my child's medical record, and to release related billing information obtained in the course of treatment of myself or my child.

PATIENT NAME:________________________________ DOB:____/______/______

RELEASE TO:____

ADDRESS:____

PHONE: (____)________________________ **FAX: (____)**____________________

I authorize the disclosure of records here in to be the following:

[] Entire Chart

[] Immunization documentation only

[] Lab and/or X-ray reports

Purpose for copying records

[] Applying for Insurance

[] Leaving the group

[] Moving out of the area

[] Other ______________________________

I consent to the release of the above specified information and/or medical records about the treatment and services received for myself or my child or agencies. I further release my attending physician and his/her associates, affiliated hospitals, its agents, and employees from any liability arising from the release of this information, as requested to the designated persons or agencies as I have listed herein.

Signature of Parent/Patient____Date______________

Print Name of Parent/Patient____

There is a fee to copy records please inquire.

There is a $10.00 fee to copy Immunization only documents.

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