DIABLO VALLEY PEDIATRICS MEDICAL GROUP

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEMBER/PATIENT HEALTH INFORMATION

Antioch Office 4049 Lone Tree Way Ste. G Antioch, CA 94531 Phone (925) 754-7070 Fax (925)754-4542 Concord Office 2299 Bacon St., Ste 7 Concord, CA 94520 (925)676-6500 (925)676-2771 Brentwood Office 1200 Central Blvd., Ste. A Brentwood, CA 94513 (925)516-6888 (925)516-9888

I hereby authorize:	Name			
Address	City		State	Zip
To Disclose To:	Name			
Address	City		State	Zip
Fax #	Email Address			
Name of Patient			Date of Birth	
Specific Records:	Medical Records	Immunizations	<i>L</i>	ab
	Claims/Billing Other (specify)			
This authorization w	vill expire:	(Specify Date) or for one y	ear from the	date of signature.
revoke or modify thi writing. I understand actions taken by Dia	ave the right to receive a constant and that my <i>revocation or m</i> blo Valley Pediatrics Medical Group receivation or materics Medical Group receivations.	e by notifying Diablo Va nodification of this authorical Group in reliance of	lley Pediatric orization will n this authori	Medical Group in not affect any zation before
There is a fee per chi	ild for copying of medical	l records: Please ask rece	eptionist for f	ee information.
Signed:		Date: _		
Relationship to patie	nt:	Contact #		
Call when ready		will pick up		