AUTHORIZATION FOR RELEASE OF INFORMATION

SECTION A: **Must be completed for all authorizations**. I hereby authorize the use/disclosure of my information as described below. I understand that this authorization is voluntary. I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without prior written authorization except as otherwise provided by law. I understand that a photocopy or fax of authorization is as valid as the original.

Note: Request form and medical record inquiries may be emailed to info@milestone-pediatrics.com but we may not send your records back via email in order to comply with HIPAA privacy laws. Thank you for your understanding.

Patient Name:_____**Date of Birth:**_____

Person(s)/organization authorized to use/disclose the information **(FROM):**

Name of Provider or Office :_____

Address:_____City_____St_____Zip_____

Phone:_____Fax#:_____

Email:_____

Person(s)/organization authorized to use/disclose the information (**To**):

Name: Milestone Pediatrics, Inc.

Address: 3435 S. Demaree, Ste A **City:** Visalia **State**: CA **Zip:** 93277
Phone: (559) 746-7337 **Fax#:** (559)746-7746

SECTION B: Need copy of records for (Please check one):
___Personal Use ___Moving ___School ____Changing Providers

SECTION C: **Check information that may need used/disclosed:**
(Please check one & include dates if appropriate or additional information at the bottom):

___Entire Medical Record	___Immunization Record	___Record Visit(s)
___PE/History report	___Laboratory Report	___Radiology Report
___Medication Record	___Mental Health	___ Consultation Report

Specific Dates or Other Requests_____
_____

SECTION D: **Check which format you want to request:**

____Paper (Parent Picks up) or ____Faxed

_____ _____

Signature of Patient Representative Date

_____ _____

Printed Name Relationship to Patient