REQUEST FOR RELEASE OF MEDICAL INFORMATION

Date: _____

Requesting From: _____ (Doctor/Medical Facility/Hospital)
_____ (Address)
_____
_____ (Phone# and/or FAX#)

Release Records To:
St. Junipero Children's Clinic
333 Abbott Street, Suite C
Salinas, CA 93901-4486

Please send the following information on:

Patient Name: _____
Date of Birth: _____
Parent/Guardian Name: _____
Relationship: _____

Signature: _____ Phone#: _____
(Member/Patient has right to a copy of this authorization)

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here: _____.
Revocation: This authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon the authorization.
Redisclosure: I understand that the receipt may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Requested Information:

_____ Shot Records _____ Labs/X-Rays

_____ Chart Notes _____ Other

_____ Discharge Summary

Select one of the following:

_____ Mail to Physician

_____ Mail to Self/Parent/Guardian

_____ Will pick up at office

The PHI (Protected Health Information) contained in this release form is HIGHLY CONFIDENTIAL. It is intended for the exclusive use of the addresses. It is to be used only to aid in providing specific healthcare services to this patient. Any other use is a violation of Federal Law (HIPAA) and will be reported as such.