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*** __________ ***Lab*** _______

Claims/Billing _________ ***Other*** *(specify)* ______________________

The reason for disclosure of health information:

____

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This authorization will expire: ___________ (Specify Date) or for one year from the date of signature.

I understand that I have the right to receive a copy of this ***authorization***; I also understand that I may ***revoke or modify*** this authorization at any time by notifying Diablo Valley Pediatric Medical Group in writing. I understand that my ***revocation or modification*** of this ***authorization*** will not affect any actions taken by Diablo Valley Pediatrics Medical Group in ***reliance*** on this authorization before Diablo Valley Pediatrics Medical Group receives by request for revocation or modification.

There is a fee per child for copying of medical records: Please ask receptionist for fee information.

Signed: ____ Date: ______________________

Relationship to patient: __________________________Contact #________________________

Call when ready________________________ will pick up______________________________

Revised 10/23/15