Salinas Pediatric Medical Group, Inc.

REQUEST FOR RELEASE OF MEDICAL INFORMATION

Date: _____

Requesting from: _____
_____
_____
_____

Releasing To: Salinas Pediatric Medical Group, Inc
505 E. Romie Lane, Suite K_
Salinas, CA 93901
Tel # (831) 422-9066
Fax: (831) 422-4312

Please send the following information on:

Patient Name: _____ Date of Birth: _____

Guardian Name: _____ Relationship: _____

Signature: _____ Telephone: _____

(Member/Patient has a 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 this authorization.
Redisclosure: I understand that the recipient 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 _____ Discharge Summaries
_____ Chart Notes _____ Other

Select **one** of the following:

_____ Fax to Salinas Pediatric Medical Group
Attention: SPMG Medical Record Fax#831-422-4312
_____ Mail To Physician
_____ Mail to Self/Parent/Guardian
_____ Will pick up at the 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.