IRVINE DOCTORS OF KIDS AND TEENS
4950 Barranca Pkwy Suite 306
Phone: 949.559.5601 Fax: 949.733.0680

Lourdes Brown, M.D.
Anna Chavez, M.D.
Grady Huckaby, M.D.
Amy Conrad, M.D.

CONSENT FOR RELEASE OF MEDIAL RECORDS

I _____ hereby authorize

Irvine Doctors of Kids and Teens, its agents, or employees to disclose Protected Health Information contained in my child's medical record, and to release related billing information obtained in the course of treatment of my child.

PATIENT NAME:_____ DOB:___/___/_____

RELEASE TO:_____

Address:_____

Phone: ( )_____ Fax: ( ) _____

I authorize the disclosure of records herein to be the following:

- ☐ Entire chart
- ☐ Immunization documentation only
- ☐ Lab and or xray

Purpose for copying records:

- ☐ Applying for insurance
- ☐ Leaving the group
- ☐ Moving out of the area
- ☐ Other _____

I consent to the release of the above specified information and/or medical records about the treatment and services received for my child or agencies. I further release my attending physician and his/her associates, affiliated hospitals, and its agents, and employees from any liability arising from the release of the information, as requested to the designated persons or agencies as I have listed herein.

Signature of Parent:_____ Date:_____

Print Name of Parent :_____

There will be a $25.00 Copy Fee for the medical Record

There will be a $ 10.00 Fee for the copy of Immunizations Record