## Consent to Release of Medical Records

I, ______________________________________________________________ hereby authorize

**Facility Name**______________________________________________________________

______________________________________________________________

**Phone(____)**______________________________**Fax(____)**______________________________

its agents, or employees to disclose Protected Health Information contained in my or my child's medical record to **Irvine Doctors of Kids and Teens**. Please mail the entire chart content to the below address. They will not receive Faxed Records. Thank you.

**PATIENT NAME:**________________________________________ DOB:_____/_______/_______

I authorize the disclosure of records here in to be the following:

[] Entire Chart

[] Immunization documentation only

[] Lab and/or X-ray reports

**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 myself or my child or agencies. I further release my attending physician and his/ her associates, affiliated hospitals, its agents, and employees from any liability arising from the release of this information, as requested to the designated persons or agencies as I have listed herein.

**Signature of Parent/Patient**________________________________________**Date**______________

**Print Name of Parent/Patient**______________________________________________________

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