ABC PEDIATRICS
ADOLESCENTS · BABIES · CHILDREN

702 WAKE AVE
EL CENTRO, CA 92243
760-352-7216
760-352-1028-FAX

CONSENT TO RELEASE MEDICAL RECORDS

I, (Your Name) _____, hereby authorize the use/disclosure of health information as follows:

ABC PEDIATRICS

702 WAKE AVE, EL CENTRO CA. 92243_

760-352-7216 / FAX: 760-352-1028

To release medical records to:

Dr.'s Name or Facility _____

Address: _____

Phone/fax #: _____

Concerning the following patient/s:

PATIENT NAME	DOB
_____	_____
_____	_____
_____	_____

-PLEASE SPECIFY THE INFORMATTION THAT IS BEEN REQUESTED (Progress notes, labs, immunization record, etc.): _____

_____

-REASON FOR THE REQUEST OF RECORDS: _____

_____

This authorization will automatically expire one year from the date of signature.
I understand I might be charge a fee for the copies of any medical information. I understand that if the medical records requested are in storage I will be charge a $25.00 fee.
I understand that medical records are confidential and may be disclosed only as authorized in this consent.

Signature _____
Relationship _____Date: _____