NORTH BAY PEDIATRICS

REQUEST FOR PREVIOUS RECORDS

AUTHORIZATION FOR USE AND/OR DISCLOSER OF PATIENT HEALTH INFORMATION

I hereby authorize: To Disclose to:

_____ 160 Glen Cove Marina Rd #103
Vallejo, Ca. 94591
Name of Disclosing Party (previous doctor) 707-648-7337, fax 707-643-6907

_____
Address

_____
City State Zip

Records and information pertaining to:

_____
Name of Patient(s) Date of Birth(s)

_____
Address City State Zip

All of the following Health Information may be disclosed FOR THE PURPOSES OF TREATMENT:

[√] Medical records and Immunizations

I understand that my health care will not be affected if I do not sign this form.
I understand that this authorization will expire one year from the date of my signature below.
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.
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.
I understand that I have a right to receive a copy of this authorization.

Signed: _____ Date: _____
Relationship to patient: _____

7-30-19 revised

* Information provided upon request in office.