AUTHORIZATION FOR ACCESS TO MEDICAL INFORMATION **(For patients 18 years & older)**

I, _____ authorize
Patient Name Date of Birth

Berkeley Pediatric Medical Group
1650 Walnut St., Berkeley, CA 94709

Dr.Annemary Franks Dr. Katrina Michel
Dr. Olivia Lang Dr. Nicole Learned
Dr. Lisa Kalar Dr. Samuel Woods
Dr. Grace So

to release my health information to:

_____
Parent or Guardian

_____
Address

_____
City State Zip

Records include a summary of care, immunization records, growth charts and pertinent medical information specific to you.

By signing this authorization I give permission for BPMG to release protected health information to the above, including verbal communication.

I may revoke this authorization in writing, at any time.

_____
Patient Signature **DATE**

_____
Printed Name