

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

I, _____ authorize the providers at:
Patient Name Date of Birth

Berkeley Pediatric Medical Group (BPMG)
1650 Walnut St., Berkeley, CA 94709

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 your child.

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

Print Name

Decline access at this time:

Patient Signature DATE

Print Name

AUTHORIZATION FOR CONSENT OF CARE

I hereby authorize Berkeley Pediatric Medical Group to examine and treat my minor

child, _____, birthdate, _____

when he/she is accompanied by _____,

relationship to patient _____.

I understand that I may revoke this consent at any time,

Parent/guardian signature

Date

Printed Name

Email to: Frontdesk@berkeleypediatrics.com or fax to (510) 848-3109

AUTHORIZATION FOR IMMUNIZATION ADMINISTRATION:

I, _____ authorize

Berkeley Pediatric Medical Group (BPMG) to administer the following vaccine/s to my child at the appropriate age/schedule according to ACIP guidelines. I have reviewed the Vaccine Information Statement.**

- Hepatitis B
 - Pentacel (DtaP, Hib & IPV)
 - Prevnar (Pneumococcal conjugate/PCV13)
 - Rotateq (Rotavirus)
 - MMR (Measles, Mumps and Rubella)
 - Varivax (Varicella)
 - Proquad (MMR & Varicella)
 - Hepatitis A
 - Tdap (tetanus, diptheria, pertussis)
 - Menactra (Meningococcal Groups ACWY)
 - Bexsero (Meningococcal Group B)
 - TruMenba (Meningococcal Group B)
 - Gardasil-9 (Human Papilloma Virus 9-valent)
 - Pneumovax 23 (pneumococcal Polysaccharide/PPSV23; *only for high-risk patients*)
- Influenza* (Inactivated)

*Please note, we often will administer seasonal Flu vaccines as an “add-on” to other vaccines at a visit if your child has not received the vaccine yet that year. By checking above you consent to this.

**All Vaccine Information Statements are available on our website, at www.berkeleypediatrics.com/office-visit-immunization/well-visits-schedules.

By signing this authorization, I give permission for the staff at BPMG to administer the above immunizations to my child. I may revoke this authorization in writing, at any time.

Child name Birthdate

Parent/guardian signature Date

Printed Name

Email to: Frontdesk@berkeleypediatrics.com or fax to (510) 848-3109