REQUEST FOR RECORDS
RELEASE OF MEDICAL RECORDS AUTHORIZATION

I hereby authorize:

_____
Physician's Name (Print)

_____
Address

_____
City State Zip Phone Number

to release medical records, including immunizations, concerning:

_____ Date of Birth: _____
Patient's Name (Print)

_____ Date of Birth: _____
Patient's Name (Print)

_____ Date of Birth: _____
Patient's Name (Print)

To: Berkeley Pediatric Medical Group
1650 Walnut Street, Berkeley, CA 94709
(510) 848-2566 Fax (510) 848-2503

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

By signing this authorization, I give permission to release and transfer my child's protected health information to the above requesting doctor for the purpose of treatment. I understand that this authorization is in effect for one year from the date signed.

_____
SIGNATURE **DATE**

_____
Printed Name **Relationship to Patient**

Thank you.

RELEASE OF RECORDS FROM BPMG
AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize **Berkeley Pediatric Medical Group**
1650 Walnut St., Berkeley, CA 94709

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

to release medical records, including immunizations, concerning:

_____ Date of Birth: _____
Patient's Name (Print)

_____ Date of Birth: _____
Patient's Name (Print)

_____ Date of Birth: _____
Patient's Name (Print)

To: _____
Physician's Name (Print)

_____
Address

_____
City State Zip Phone Number

Reason for Request:

____Transferring care ____Change of Insurance Coverage

____Moving

New address: _____

_____

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 and transfer my child's protected health information to the above physician for the purpose of treatment. I understand that this authorization is in effect for one year from the date signed.

_____
SIGNATURE **DATE**

_____
Printed Name **Relationship to Patient**