

WEST HILLS CHILDREN'S MEDICAL GROUP

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Authorization for Release of Medical Information

Patient's Name: _____ Date of Birth: _____

Signature of Parent/Guardian: _____ Date Requested: _____

I authorize West Hills Children's Medical Group to

Release Medical Information to:

Name of Provider

Address of Provider

City/State/Zip Code of Provider

Phone Number/Fax Number (Including area code)

_____ Complete Medical Records _____ Immunizations _____ Consultations

_____ Summary of Medical Records _____ Labs

_____ Other _____

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This authorization is valid for 90 days