Authorization for Release of Medical Record

To:

____
Doctor/Hospital/Office Name

____
Address

____
Phone number & Fax Number

I herby authorize and request you to release to:

West Hills Children's Medical Group
7301 Medical Center Dr.#300
West Hills, Ca. 91307
Tel: 818-593-5439
Fax: 818-593-3460

__ Complete Medical Records __ Immunization Records __ Consultations

__ Summary of Medical Records __ Labs

__Other____

Patient's Name: ______________________________ DOB: ______________

Parent/Guardian Name:__________________ Relationship to Patient: ____________

Signature:__________________________ Date:__________________________

This authorization is valid for 90 days

This message is intended only for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosures under applicable law. If the reader is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited you have received this communication in error, please notify us immediately by telephone and return the original message to us at the above address via U.S. Postal Service. Thank You.

Please fax records to: 818-593-3460