VALLE VERDE PEDIATRICS
FOR HAPPY AND HEALTHY CHILDREN

Authorization for Release of Protected Health Information

Patient Name: _____
Last First MI Maiden or Other Name

Date of Birth: ____-_____-_____ Medical Record #: _____ Phone: _____

Address: _____City: _____ST: _____Zip: _____

Date of Service: _____

☐ **I authorize** Valle Verde Pediatrics to release the following records related to the date(s) above:

Records: ☐ All records

☐ Medical Records
☐ Diagnostic Records (lab, x-ray, etc.)
☐ Treatment Records
☐ Billing/Claims Records

To include:
☐ HIV/STD
☐ Drug and alcohol related
☐ Mental Health

Please release these records to: ☐ COVERED ENTITY or ☐ INDIVIDUAL LISTED BELOW

NAME: _____

ADDRESS: _____ CITY: _____STATE: _____ZIP: _____

PHONE: _____ FAX: _____

☐ For purposes of treatment, payment, health care operations, or ☐ other _____

This authorization will remain in effect for one year from the date that it is signed. Permissions for further use or disclosure of this medical information are not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.
I have been advised of my right to receive a copy of this authorization.

_____ _____ OR _____ _____
SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

_____
RELATIONSHIP TO PATIENT

Valle Verde Pediatrics
15525 Pomerado Rd, Suite B-3
Poway, CA 92064
Phone: 858-487-8333
Fax: 858-487-0856