Patterson & Tedford Pediatrics
with you every step of the way

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CONSENT TO RELEASE MEDICAL INFORMATION
to Patterson and Tedford Pediatrics

Physician(s) Releasing Information: _____

_____

_____

Physician(s) Phone #: _____

Information to be Released: ☐ Immunization Records Only ☐ Entire Chart

The purpose for information to be used/disclosed: ☐ Continued Care ☐ Personal Use

☐ Other _____

Release Records To: PATTERSON AND TEDFORD PEDIATRICS
7700 MORRO ROAD
ATASCADERO, CA 93422

Medical Records fax # 805-466-6603

PLEASE DO NOT FAX MORE THAN 15 PAGES!!

Patient Name: _____ **Date of Birth**: _____

Telephone Number: _____

This authorization will expire after this request is fulfilled and shall not extend beyond 180 days from the date of signature.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this protected health information

_____ _____
Signature of Patient or Representative **Today's Date**

_____ _____
Printed Name of Patient's Representative **Relationship to Patient**