



Livermore Pleasanton San Ramon Pediatrics Group

Infants • Children • Adolescents

Section A: (Must be completed for ALL authorizations)

Rev 03/12

I, _____, understand that LPSR Pediatrics Group is authorized by me to use, release, and/or disclose the Protected Health Information (PHI) as described below. I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by the privacy regulations.

If you or your child(ren) are transferring to another practice there will be a \$30.00 (per child) fee per chart that must be paid in full before chart is transferred.

****IF THIS REQUEST IS FOR RECORDS TO BE SENT TO LPSR PEDIATRICS GROUP, THIS FORM IS TO BE MAILED OR FAXED BY THE PARENT AND NOT BY LPSR PEDIATRICS GROUP.**

We DO NOT transfer previous doctor record's, you must request them directly from your previous doctor(s).

Patient's Name: _____ Date of Birth: _____

Patient's Address: _____ Phone#: _____

City: _____ State _____ Zip _____

RELEASE FROM:

SEND TO:

Name: _____ Name: _____

Address: _____ Address: _____

City/State/Zip: _____ Phone: _____ City/State/Zip: _____ Phone: _____

Section B: (Must be completed for ALL authorizations)

I authorize the following information to be sent to the above address: (Check all that apply)

Copies of Complete Medical Records for the period:

____/____/____ to ____/____/____
Mo Day Year Mo Day Year

OR

Copies of information described below for the period:

____/____/____ to ____/____/____
Mo Day Year Mo Day Year

History & Physical Examination

Reports from other physicians, Lab, X-Ray, etc.

Other (Please Specify) _____

The following information should NOT be released (Please specify) _____

Specific Authorization Required for the Following: HIV Information: Yes No Initials _____

Drug/Alcohol Information: Yes No Initials _____ Mental Health Information: Yes No Initials _____

Reason for transfer/disclosure: _____

If transferring for insurance reasons, please specify which insurance company: _____

I understand that:

- I may revoke this authorization at any time by notifying the Practice's HIPAA Privacy Officer in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively. I may request a copy of the protected health information to be used or disclosed.
- This authorization will expire one year from today's date unless otherwise specified.
- LPSR Pediatrics Group assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization.

Patient/Parent/Guardian Signature: _____ Phone _____ Date _____

Please note: This signature will be compared to the signature we have on record in your child(ren's) chart.