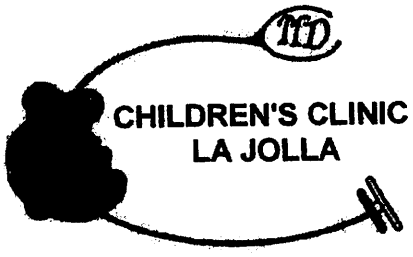

AUTHORIZATION TO RELEASE MEDICAL RECORDS

This authorization to release medical information is in accordance to the Confidentiality of Medical Act of 1981, Section 56 et seq. of the California Civil Code.

I hereby authorize:

Name_____ Phone(____)_____Fax(____)_____
(Previous Physician, Hospital, or Healthcare Provider)

Complete Address_____

To release my records to:
Children's Clinic La Jolla
5726 La Jolla Blvd, Suite 107
La Jolla, CA 92037
Phone (858)459-5437
Fax (858)459-5459

Please release **ALL MEDICAL INFORMATION** including diagnosis and records of any treatment or examination rendered to the following physician(s):_____, MD

Please: ___Fax the records ___Mail the records ___Have ready for pick-up___/___/___

Patient Name:_____ DOB_____/_____/_____

Sibling Name:_____ DOB_____/_____/_____

Sibling Name:_____ DOB_____/_____/_____

Authorized Signature:_____

Print Name:_____

Date:_____/_____/_____ ***This authorization is valid for one year from signature date.**

CHILDREN'S CLINIC
LA JOLLA

S. Daman Paul, MD
Gretchen Gainor, MD
Asako Komiya, PNP,RN
Amrita Dosanjh, MD

5726 La Jolla Blvd. Sutie 107, La Jolla CA 92037
Phone: (858)459-5437 Fax: (858)459-5459

AUTHORIZATION TO RELASE HEALTHCARE INFORMATION

Patient's Name_____ DOB_____/_____/_____

Siblings Name_____ DOB_____/_____/_____

I request and authorize **Children's Clinic·La Jolla 5726 La Jolla Blvd, #107, La Jolla, CA 92037** to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State:_____ Zip:_____

Reason for Release:

_____

This request and authorization applies to:

__Health information relating to the following treatment , condition, or dates: _____

_____

__All health care information: _____

__Other: _____

____Yes ____No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Parent/Guardian Signature: _____ Date:____/_____/_____

Parent Name: _____

M.D. Approval to Release Medical Record

_____