Marin Pediatric Associates, Inc.

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AUTHORIZATION TO RELEASE YOUR MPA MEDICAL INFORMATION 5/19

Please provide all information requested or this authorization is not valid. Please print.

$35 or $45 records release fee* (plus postage): Check enclosed ❑ or Cash paid in person ❑ or Credit Card # (Visa/MasterCard) _____Sec.Code _____ Exp. Date _____

I hereby authorize Marin Pediatric Associates to provide medical information to:

Name:	Phone: ( )
Address:	Fax: ( )
City, Sate, Zip:	

Records pertaining to:

Patient's Name:_____DOB:_____
Dates of Treatment:_____

Data Requested: (Please ***initial*** appropriate choices. X or ✓ are ***not*** acceptable.)

_____ Portions of Medical record necessary for ongoing care, including shot records, X-ray reports, lab reports, consultations
_____ Mental Health information
_____ Drug/Alcohol information
_____ HIV test results
_____ Genetic records
_____ Developmental/Learning disorders
_____ Other (Specify):_____

For the **Purpose** of: ❑ ongoing healthcare ❑ other:_____
Permission to fax and/or send electronically: ❑ Yes ❑ No
All faxed material will contain a confidentiality statement: however, I understand confidentiality at the receiving end cannot always be assured.

Duration: This authorization is effective for 1 year from the date of signature, or expires on:_____(date)

Revocation: This authorization may be revoked at any time, except to the extent that action has been taken on this authorization.

Rediscloseure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I understand that there will be a $35-$45 charge*, plus postage, per patient for these records. (The higher fee applies to charts with more than 25 pages of material, or a "Rush"(needed in less than 2 wks request)

_____

Signature: Patient (if ≥ 18 yr), Parent, Legal Guardian, Representative Relationship to Patient date

***a surcharge of up to $25 may apply if you are requesting the entire medical record, or for charts >100 pages**

For Office Only: Approved for release by PCP: _____ Copied by: _____ date: _____ mailed / faxed / picked up on date: _____