



SOUTH EASTBAY PEDIATRIC MEDICAL GROUP
Authorization To Transfer/Copy/Inspect Health Information

- Transfer records Copy of records Inspect records

Date: _____

Patient's Name: _____

Patient's Birth Date: _____

I hereby authorize **SOUTH EAST BAY PEDIATRIC MEDICAL GROUP** to Transfer/Copy/Disclose ALL or a portion of health information relating to my child's care to the physician or entity named below:

- If a partial release or disclosure authorization; the **portion** of the records concerning:

To my **NEW PHYSICIAN OR OTHER ENTITY FOR CARE OF THIS PATIENT** at the following address:

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP CODE
: _____

PHONE NUMBER: (____) ____ - _____

- I hereby request to **Inspect** all or a portion of health information relating to my child's care.
 I hereby request a copy and release of the above named patient's medical record as the:
 Patient Parent or Guardian of the minor patient

The reason for my request:

(FEE- A \$10.00 service charge plus .25 cents per page will apply if records are not released directly to another physician or medical facility.)

Parent signature: _____

Parent name: _____

Phone: (____) ____ - _____

- mother father other

THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM ABOVE DATE.

I do not have to sign this authorization in order to receive treatment from SOUTH EAST BAY PEDIATRIC MEDICAL GROUP. I have the right to refuse to sign this authorization. After this patient's information is transferred or disclosed to the physician or entity named above, it may be transferred or disclosed again by them and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

SOUTH EAST BAY PEDIATRIC MEDICAL GROUP
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