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Date _____

Dear Dr. _____

I herewith authorize release of medical records to:

Doctor's Name _____

Address _____

City _____ State _____ Zip _____

Regarding:

Last Name First Name DOB

Last Name First Name DOB

Last Name First Name DOB

This authorization for use or disclosure of my/my child's health information is required by state and federal law. California law prohibits the recipient from making further disclosure of your health information unless another authorization is obtained or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside of California.

I may revoke this authorization at any time, in writing. The revocation must be signed by me or on my behalf and sent to the address at the top of this form. The revocation is effective upon receipt but will have no impact on uses or disclosures made while the authorization was valid.

This authorization shall be valid until _____

Please indicate a date after which no information can be released. If no date is given, authorization will be valid for 90 days.

Signature _____ Printed Name _____

Relationship to patient (circle one): Self Parent Guardian Date _____