

LOS ROBLES PEDIATRIC MEDICAL GROUP, INC  
 Timothy L. Hirsch, M.D. Miriam H. de Lyon, M.D. Tammy S. Chi, M.D. Edward T. Chambers, M.D.  
 Infants, Children and Young Adults  
 299 W. Hillcrest Drive, Suite 100  
 Thousand Oaks, CA 91360  
 Telephone: (805) 497-7888 Fax: (805) 494-3498

**AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE  
 OF MEDICAL INFORMATION**

Please **SEND** Medical Information **TO:**

Name of Person or Entity to Receive Information: \_\_\_\_\_

Title (Physician, Therapist, Attorney, etc.): \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, and Zip Code: \_\_\_\_\_

I hereby authorize **LOS ROBLES PEDIATRIC MEDICAL GROUP, INC.** to release and/or disclose  
 The medical information as indicated below to the health care provider, entity, or person I have indicated above.

Release and/or disclose records and information regarding:	<b>Date of Birth:</b>
<b>Patient Name:</b>	
_____	_____
_____	_____
_____	_____
_____	_____

**Duration:** This authorization shall become effective immediately and shall remain in effect until \_\_\_\_\_ (enter date)  
 or for one year from the date of signature if no date is entered.

**Revocation:** This authorization may be revoked in writing by the undersigned at any time prior to the release of  
 information from the disclosing party. Written revocation will not affect any action taken in reliance  
 on this authorization before the written revocation was received.

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

**Specify records to be released and/or disclosed:**  
*Please initial next to each request*

General Medical Information  
 (from \_\_\_\_\_ to \_\_\_\_\_) \_\_\_\_\_

Information regarding specific injury/treatment  
 (from \_\_\_\_\_ to \_\_\_\_\_) \_\_\_\_\_

X-Ray/Laboratory Results \_\_\_\_\_

Mental Health \_\_\_\_\_

Alcohol/Drug \_\_\_\_\_

HIV Test Result \_\_\_\_\_

Other (specify): \_\_\_\_\_

I request that the health information released and/or  
 disclosed pursuant to this authorization be used  
 for the following purposes only: \_\_\_\_\_  
 \_\_\_\_\_

A copy of this authorization is valid as an original.  
 I have the right to receive a copy of this  
 authorization.

_____ Date	_____ Signature of Patient or Patient's Representative	_____ Indicate Relationship (If signed by other than patient) 7/13
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