SOUTHWEST PEDIATRICS
Hitesh Shah MD, F.A.A.P.
Charity Santiago MD, F.A.A.P.
Allyson Self MD, F.A.A.P.

AUTHORIZATION TO RELEASE INFORMATION FROM THE MEDICAL RECORD

Patients Name____

Address_______________________________State______Zip__________

Birthdate________________Mother's Last Name____________________

I, the undersigned, hereby authorize:

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To provide from the Patient's Medical record the information specified below to:

____

For the Purpose of____

The information supplied is to be restricted to (specify medical info)______________________

And/or for (specify time period to be covered)______________________________

Release or transfer of the specified information to any person or entity specified herein is prohibited. An additional consent must be obtained for any proposed new use of the information or for it's transfer to another person or entity.

A copy of this authorization is as valid as the original. I understand, I have the right to a copy of this form upon request.

This authorization shall be valid until (date)______________________________

Patient Signature______________________________Date________________

Or legal representative___________________________Date________________

Relationship to patient____

9802 Stockdale Hwy Suite 103 Phone (661)663-4444 Fax (661)663-4100