

Southwest Pediatrics
Hitesh Z. Shah, M.D., F.A.A.P.
Charity O. Santiago, M.D.
6001-A Truxtun Ext., Suite 180
Bakersfield, CA 93309

**AUTHORIZATION TO RELEASE
INFORMATION FROM THE
MEDICAL RECORD**

PATIENT'S NAME _____

Last

First

Middle

ADDRESS _____ STATE _____ ZIP _____

BIRTHDATE _____ MOTHER'S MAIDEN NAME _____

I, THE UNDERSIGNED, HEREBY AUTHORIZE:

1. _____
2. _____
3. _____
4. _____

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) _____

SIGNATURE:

PATIENT _____ DATE _____

OR LEGAL REPRESENTATIVE _____ DATE _____

RELATIONSHIP TO PATIENT _____