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AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

I hereby authorize _____ to release confidential medical information and records regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-ray, correspondence and/or medical records by means of mail, fax or other electronic methods.

This authorization is for:

__ Immunizations only

__All records

__Limited to the following medical information _____

__For a specific time period from_____ to _____

Release to:

Simi Pediatric Partners
2950 N. Sycamore Dr. #200
Simi Valley, CA 93065

Permission for further use of disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

_____ _____
Patient Name Patient Date of Birth

_____ _____
Signature of patient or legal/personal guardian Relationship if other than patient

_____
Date