

# NORTH BAY PEDIATRICS

## REQUEST FOR PREVIOUS RECORDS

### AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PATIENT HEALTH INFORMATION

I hereby authorize:

To Disclose to:

\_\_\_\_\_ [ ] 2001 Springs Rd., Vallejo, Ca. 94591  
Name of Disclosing Party (previous doctor)

[ ] 1075 First St., Benicia, Ca. 94510

\_\_\_\_\_ [ ] 1455 Oliver Rd., #250, Fairfield, Ca. 94534  
Address

\_\_\_\_\_  
City State Zip

Records and information pertaining to:

\_\_\_\_\_  
Name of Patient(s) Date of Birth(s)

\_\_\_\_\_  
Address City State Zip

All of the following Health Information may be disclosed FOR THE PURPOSES OF TREATMENT:

Medical records and Immunizations

I understand that my health care will not be affected if I do not sign this form.

I understand that this authorization will expire one year from the date of my signature below.

This authorization is also subject to written revocation by the member/patient at any time.

The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

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

I understand that I have a right to receive a copy of this authorization.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_