Authorization for Release and/or Disclosure of Medical Information

1. **I hereby authorize:**
   - ☐ Casa Verde Pediatrics, Inc./Dr. Lisa M. Asta 301 Lennon Ln. Ste. 203 Walnut Creek, CA 94598
     Phone: (925)939-7334 Fax: (925) 939-7340

   - ☐ Other (specify):_____
     Phone: (_____) _____ Fax: (_____) _____

2. **To release and/or disclose the medical information to the person/entity I have indicated below:**

   - ☐ Person/Entity authorized to receive the information:

   _____

   Address- Street, city, state, zip code, phone, and fax:

   _____

   - ☐ Casa Verde Pediatrics, Inc./Dr. Lisa M. Asta 301 Lennon Ln. Ste. 203 Walnut Creek, CA 94598
     Phone: (925)939-7334 Fax: (925) 939-7340

3. **This authorization applies to the following health information:**
   - ☐ All Medical Records
   - ☐ Immunization records
   - ☐ Growth charts
   - ☐ School or day care forms
   - ☐ Information regarding specific injury or treatment (specify dates)_____
   - ☐ Imaging reports (specify dates)_____
   - ☐ Laboratory results (specify dates)_____
   - ☐ Other specific records/types of health information (including dates):

   _____

   - ☐ **I specifically authorize the release of the following information (check as appropriate):**
     ☐ **Mental health** ☐ **HIV test results** ☐ **Alcohol/drug treatment information**

4. **I request that the health information released and/or disclosed pursuant to this authorization be used for the following purposes only:** ☐ Further medical care ☐ Other:_____

5. **Expiration:** This authorization shall become effective immediately and shall remain in effect until _____ (date) or for one year from the date of signature if no date entered.

6. **Preferred method of delivery:** ☐ Pick up ☐ Mail (postage charged) ☐ Access to view the record above (no fee)
   Preferred format: ☐ CD ☐ Paper copies made of the record indicated ☐ Other
   ☐ Fax up to 10 pages_____ (Please Initial) Patient requests records to be faxed to another facility or physician's office. Patient is aware of the confidentiality risks involved and releases Casa Verde Pediatrics, Inc. and Lisa M. Asta, MD from responsibility for faxing to the following number: (_____) _____.

CONTINUE ON OTHER SIDE →

Authorization for Release and/or Disclosure of Medical Information

RESTRICTIONS

According to federal and state regulations, if the medical information requested relates to AIDS/HIV treatment or treatment in a federally recognized chemical dependency unit, then the information will be accompanied by a statement limiting disclosure to third parties as required by law. I understand if the person or entity that receives the information is not a health care provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. I realize that the office and its employees have a responsibility to maintain the confidentiality of the medical records in its possession. I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. The office will not be held responsible for any subsequent disclosure by the recipient of the health information. I release Casa Verde Pediatrics Inc, Lisa M. Asta, MD, and employees of any liability that may arise as a result of any subsequent disclosure of my health information by the recipient.

MY RIGHTS

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of. I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: 301 Lennon Ln. Ste. 203 Walnut Creek, CA 94598. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization. I have a right to receive a copy of this authorization. Information disclosed pursuant to this authorization could be re-disclosed by the recipient.

CLERICAL CHARGES

If copies or record transfer is requested, I acknowledge that the law requires me to pay reasonable clerical costs and permits copying fess of $0.25 per printed page, plus postage for mailing copies. I acknowledge that the charge for electronic copies is based on the cost of supplies for provided electronic media, the cost of skilled labor and technical skill to produce the electronic copy, plus postage.

Signature:_____ **Date**: _____ **Time**: _____**Phone**: _____

Print Patient Name:_____**Date of Birth**:_____

Print Requestor Name (if other than patient):_____

Relationship to Patient: □ Legal Representative □ Parent/Guardian □ Spouse