

RELEASE OF MEDICAL RECORDS AUTHORIZATION

I hereby authorize:

Physician's Name (Print)

Address

City State Zip

to release medical records, including immunizations,
concerning:

Patient's Name (Print)

Birthdate:_____

To: Berkeley Pediatric Medical Group
1650 Walnut Street, Berkeley, CA 94709
(510) 848-2566

Dr. James G. Cuthbertson Dr. Annemary Franks
Dr. Elaine E. Davenport Dr. Olivia Lang
Dr. Benjamin N. King Dr. Lisa S. Kalar

By signing this authorization I give permission to release and transfer my child's protected health information to the above requesting doctor for the purpose of treatment. I understand that this authorization is in effect for one year from the date signed.

SIGNATURE **DATE**

Printed Name **Relationship to Patient**

Thank you.