AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize **Berkeley Pediatric Medical Group**
1650 Walnut St., Berkeley, CA 94709

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

to release medical records, including immunizations, concerning:

_____
Patient's Name (Print)

Birthdate:_____

To: _____
Physician's Name (Print)

_____
Address

_____
City State Zip

Reason for Request: ____Transferring care

____Moving ____Parents want copy

New address:_____

_____

____Summary of care, immunization record and growth charts. No Charge

____Entire chart, $35.00, payable at the time of the request.
(For multiple family members, please allow extra time)

By signing this authorization I give permission for BPMG to release and transfer my child's protected health information to the above physician 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**