Berkeley Pediatrics

1650 Walnut Street, Berkeley, CA 94709
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REQUEST FOR RECORDS

I hereby authorize:

_____
Physician's Name (Print)

_____
Address

_____
City State Zip Phone Number Fax Number

to release medical records, including immunizations, concerning:

_____ Date of Birth: _____
Patient's Name (Print)

_____ Date of Birth: _____
Patient's Name (Print)

_____ Date of Birth: _____
Patient's Name (Print)

(Our office is on EPIC EHR through UCSF. Please contact our office if we can request the records electronically through EPIC.)

To: _____
Berkeley Peds Physician's Name

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

_____
Parent/Guardian's Name Relationship to Patient