Berkeley Pediatrics

1650 Walnut Street, Berkeley, CA 94709
Phone: 510-848-2566 Fax: 510-848-3109
www.berkeleypediatrics.com

RELEASE OF RECORDS

I hereby authorize **Berkeley Pediatric Medical Group:**

_____
Physician's Name

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)

To: _____
New Physician's Name (Print)

_____
Address

_____
City State Zip Phone Number Fax Number

Reason for Request:

____Transferring care _____Change of Insurance Coverage _____Moving

New Address: _____

Records include a summary of care, immunization records, growth charts and pertinent medical information specific to your child. 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

_____
Parent/Guardian's Name Relationship to Patient