

# PEDIATRIC GEMS, PC EDMOND SARRAF, MD

[www.pediatricgems.com](http://www.pediatricgems.com)  
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## Authorization to Release Medical Information

1. I AUTHORIZE:

2. TO RELEASE TO:

\_\_\_\_\_  
Name of sending person/organization

\_\_\_\_\_  
Name of receiving person/organization

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
City State Zip Code

3. NAME OF CHILD OR DEPEND-  
ENT: \_\_\_\_\_

4. DATE OF BIRTH OF CHILD OR DEPEND-  
ENT: \_\_\_\_\_

5. INFORMATION TO BE RELEASED: (Check all applicable)

All Information  Immunization Records ONLY  All Progress Notes  Lab Reports  
 X-ray Reports  Allergy Records  Consultant Letters  Other: \_\_\_\_\_

6. RECORDS FROM THE TIME PERIOD: \_\_\_\_/\_\_\_\_/\_\_\_\_ through \_\_\_\_/\_\_\_\_/\_\_\_\_

7. PURPOSE OF DISCLOSURE: (Check applicable purpose)

Transfer of Medical Care  Personal  For Other Medical Provider  
 Personal  Other: \_\_\_\_\_

8. I understand that this authorization shall be valid for one year. I understand that I may re-  
voke this consent at any time.

9. I understand that a reasonable fee may be charged for duplication of records. An estimate of  
those charges will be \$25.00 due prior to records being transferred.

10. The requestor may be provided with a copy of this authorization.

Patient's Signature (if over 18 years old): \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Parent or Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

\_\_\_\_\_  
For office use  
only: \_\_\_\_\_

\_\_\_\_\_  
MR# Date Initials of Staff Member

**SPECIAL AUTHORIZATION:** Check applicable box(es) and sign immediately below.

By signing below, I am authorizing the office to release any and all information regarding:

Alcohol  Drugs  Mental Health  Sexually Transmitted Diseases  HIV  AIDS

Patient's Signature (IF OVER 18 YEARS OLD): \_\_\_\_\_ Date: \_\_\_\_\_