OC Pediatrics Medical Group, Inc.

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ____________

I request and authorize:

Office/hospital: ______________________

Address: ______________________

Number: Phone: ____________ Fax: ____________

To release healthcare information of the patient named above to:

OC Pediatrics Medical Group, Inc.
26700 Towne Centre Dr. Ste 150
Foothill Ranch, CA 92610

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ____________

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☐ All healthcare information

☐ Other: ______________________

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Parent/Patient Signature: ______________________ Date Signed: ____________

Parent/Patient Name: ______________________

Witness Signature: ______________________ Date Signed: ____________

Witness Name: ______________________

26700 Towne Centre Dr. Ste. 150
Foothill Ranch, CA 92610
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