OC Pediatrics Medical Group, Inc.

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ____ Date of Birth: __________

I request and authorize:

Office/Hospital: ____

Address: ____

Phone: ________________________ Fax: _____________________

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition, on date: _______
- All healthcare information
- Other (specify)____

This Authorization will remain in effect:

- From the date of this authorization until: _______________________________________
- Until the following event occurs: ____

  Unless otherwise noted above this authorization will remain in effect 180 days from the date signed.

Signature of Patient or Legal Representative: ____

Print Name: ____

Date: ______________