



Children's Medical Group

8945 Magnolia Avenue, Suite 205 • Riverside, CA 92503

Office (951) 689-9220 • Fax (951) 689-8377

www.iecmg.org

AUTHORIZATION FOR THE RELEASE OF INFORMATION OF PROTECTED HEALTH RECORDS

I hereby authorize you to release to:

DR. _____

Inland Empire Children's Medical Group

8945 Magnolia Avenue Suite #205

Riverside, CA 92503

Fax (951) 689-8377

For the purpose of review/examination and further authorize you to provide such copies of the records as may be requested. The forgoing is subject to such limitations as indicated:

___ Entire record (including growth chart)

___ Specific Information

___ Old records from previous physician

Please forward the above indicated request during the period from:

_____ to _____

Child's Name

Parent Signature

Date of Birth

Witness

Date

Name and address of previous physician:

Name

Phone

Address

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and provide my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that this revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months. This authorization will automatically expire six months from the date signed, unless otherwise indicated. I understand that I may revoke this consent at anytime except to the extent that action has been taken in reasonable reliance upon the document.

Signature of parent or legal guardian

Date