

Inland Empire



Children's Medical Group

7101 Magnolia Avenue, Suite A • Riverside, CA 92504

Office (951) 682-9780 • Fax (951) 682-9787

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