# Mia Bella Pediatrics, Inc.
# Medical Records Release

Please complete the following information:

Patient Name: _____
Address: _____
_____
Phone: _____
Date of Birth: _____/_____/_____ SSN:_____

I authorize the custodian of records of: Mia Bella Pediatrics, Inc or other person/entity (specify):_____ to disclose/release the following information*
(check all applicable):

- ☐ General Medical Information (from ____ to ____)
- ☐ Laboratory/pathology records
- ☐ X-ray/radiology records
- ☐ Immunization Record
- ☐ Pharmacy/prescription records
- ☐ Other (specify): _____

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

| Please **send** the records listed above **to**: | Please **request** medical information **from**: |
|---|---|
| Name: Mia Bella Pediatrics, Inc. | Name: _____ |
| Address: 26161 La Paz Rd, Suite 115<br>Mission Viejo, CA 92691 | Address: _____<br>_____ |
| Phone: (949) 206-0001 | Phone _____ |
| Fax: (949) 206-0011 | Fax: _____ |

Duration: This authorization shall become effective immediately and shall remain in effect until ___/___/___ (enter date) or for one year from the signature if no date entered.

Revocation: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

Disclosure: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

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A copy of this authorization is valid as original.
I have the right to receive a copy of this authorization.

_____ ____/____/____
Signature of Patient or Patient's Representative Date(mm/dd/yyyy)

_____ _____
Printed name of patient representative and Relationship, *(i.e parent, guardian, etc)*