



# CARMEL VALLEY PEDIATRICS

comprehensive care and a gentle touch – woven together for healthy kids

Carmel Valley Pediatrics  
Chrystal de Freitas, M.D., F.A.A.P.  
12395 El Camino Real Suite 315  
San Diego, CA 92130  
(858) 794-5437  
(858) 794-5439 fax

## Authorization for Release of Medical Records (PHI - Protected Health Information)

From: Carmel Valley Pediatrics

To: \_\_\_\_\_  
Practice Name/Physician's Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip

**Please include information regarding the following:**

- |                                               |                                                |                                           |
|-----------------------------------------------|------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Birth History        | <input type="checkbox"/> Allergies             | <input type="checkbox"/> Hospital Records |
| <input type="checkbox"/> Growth & Development | <input type="checkbox"/> Current Medical Needs | <input type="checkbox"/> Psych Records    |
| <input type="checkbox"/> Immunizations        | <input type="checkbox"/> Consultations         | <input type="checkbox"/> Misc. Records    |

**I wish to exclude:** \_\_\_\_\_ medical information from being released.

1. You have the right to revoke this authorization in writing unless the Medical Records (PHI) have already been released or if otherwise prohibited by state or federal law.
2. Treatment, payment, enrollment, or eligibility for benefits may not be a condition to release Medical Records (PHI). A signed authorization is a requirement in order for Medical Records (PHI) to be released.
3. When this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by above party and may no longer be protected by the HIPAA Privacy Rule. Carmel Valley Pediatrics will continue to maintain the confidentiality of our patient's Medical Records (PHI) mandated by the federal HIPAA Privacy Rule.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Printed name of parent or guardian

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date

Expiration date: \_\_\_\_\_

(Expires in 1 year unless otherwise noted)