

**Authorization for Use and Disclosure of Protected Health  
Information**

RAMBLC Pediatric Medical Group

14880 Los Gatos Blvd  
Los Gatos, CA 95032  
phone (408) 371-7777  
fax (408) 371-7147

Patient name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

RAMBLC Physician: \_\_\_\_\_

This form, when signed, gives authorization for RAMBLC Pediatric Medical Group, Inc. to release the indicated type(s) of information from the patient's medical record. Check boxes below indicating which items we may release:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Record of office visits    | <input type="checkbox"/> Lab results (excluding HIV) | <input type="checkbox"/> X-ray results         |
| <input type="checkbox"/> Specialist consult reports | <input type="checkbox"/> Immunization records        | <input type="checkbox"/> Mental health records |
| <input type="checkbox"/> Drug/alcohol records       | <input type="checkbox"/> HIV blood test results      | <input type="checkbox"/> Hospital records      |
| <input type="checkbox"/> Other (specify): _____     |  |  |

Name of persons or facilities to whom the information may be disclosed (i.e. school, daycare, camp, etc.)

_____	_____
_____	_____
_____	_____

This authorization is effective indefinitely, unless revoked or terminated by the patient or the patient's personal representative. You may revoke or terminate this authorization by submitting a written revocation to RAMBLC Pediatric Medical Group. Contact your primary care physician to terminate this authorization.

The information that is disclosed under this authorization may be disclosed again by the person or organization to which it has been sent. The privacy of this information, once sent by our office, may not be protected under federal privacy regulations.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed name \_\_\_\_\_

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