

HUNTINGTON PLAZA PEDIATRIC GROUP

A Medical Group
800 Fairmount Ave, Suite 110
Pasadena, CA 91105
Phone: (626) 795-7051 Fax: (626) 795-1859
medicalrecords@hpphmail.com

Audrey Reid, M.D., M.P.H., F.A.A.P.
Jennifer Cohen, M.D., F.A.A.P.
Francisco Rivera, M.D., F.A.A.P.
Sharon Wollaston, M.D., F.A.A.P.
Ruby Batin, M.D.

Please complete the attached medical release form and return it to our office at your earliest convenience. Please allow up to 1 week for your request to be processed. You may submit your request in person, by mail, fax or email.

New Patients

We will forward your request to your prior doctor's office. Please be sure to include the address and phone/fax number of the facility you are requesting records from or we will be unable to process your request.

Current Patients

If you are moving or switching doctors please include the address and phone/fax number of the doctor's office to which the records are being forwarded. If this contact information is not included on the release form we will be unable to process your request.

If you are requesting the **ENTIRE CHART** to be copied, there is a \$25.00 fee that needs to be collected before the records can be copied and transferred. For free of charge we will provide you with the patient's immunization record, growth chart, most recent physical and summary sheet (if applicable).

If you have any questions or concerns, please contact:

Huntington Plaza Pediatric Group
Medical Records Department
(626) 795 7051 ext. 127
medicalrecords@hppgmail.com

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Consent Release of Medical Information

The authorization for use of medical information is being requested of you to comply with the requirements of California Civil Code Section 56, et seq.

Patient Name: _____ Date of Birth: _____

I Hereby Authorize:

Name of healthcare provider: _____

Address: _____

Phone: _____ Fax: _____

To release my medical records and request that they be forwarded to:

Name: _____

Address: _____

Phone: _____ Fax: _____

Items To Be Copied:

<input type="checkbox"/> Labs	<input type="checkbox"/> Immunization Report
<input type="checkbox"/> X-rays	<input type="checkbox"/> Standard Copy (free)
<input type="checkbox"/> Consultation Report	<input type="checkbox"/> Entire Chart
<input type="checkbox"/> Hospital / ER Report	Other: _____

I understand that requester may not further use or disclose this information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Date: _____ Signature: _____