Huntington Plaza
PEDIATRICS

Sushil Anand, M.D., F.A.A.P
Nazifah Khairullah, M.D., F.A.A.P
Francisco Rivera, M.D., F.A.A.P
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Lori Lee, M.S.N., C.P.N.P

# 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 (Facility Medical Records Are Being Obtained From):

**Name of Healthcare Provider:** _____

**Address:** _____

**Phone:**_____ **Fax:** _____ **Email:**_____

To Release My Medical Records & Request They be Forwarded To:

**Name:** _____ **Relationship: Self/Parent/Doctor/Other**_____

**Address:** _____

**Phone:**_____ **Fax:** _____ **Email:**_____

Items to be Copied:

____ Standard Records Copy (Vaccine Record, Growth Chart, Most Recent Physical)

_____ Consultation ____ Hospital/ER Report/Specialist Notes

_____ Immunization Record ____ Labs

_____ All available records (Please note copying charges start from $100 and up)

Reason for Release of Medical Records: _____

I understand that the requester or recipient of these medical records may not further use or disclose this protected health information unless another authorization is obtained or such use or disclosure is specifically required or permitted by law.

Date:_____ Signature: _____

Name of Patient or Representative:_____

800 Fairmount Ave, Suite 110
Pasadena, CA 91105
Phone (626) 795 7051 Fax (626) 795 1859

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Please complete the attached medical release form & 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 or by mail, fax or email. Expiration of authorization effective immediately after request has been processed and completed.

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

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

HIPAA Compliant Authorization for the release of Medical Records:

- The recipient of the protected health information under the authorization will not re-disclose the information, except with a written authorization or as specifically required or permitted by law.
- HPPG will not condition the provision of care or the receipt of benefits on the signing of the authorization.
- The patient will receive a copy of the completed authorization form upon request.
- The patient or patient's representative has the right to revoke authorizations in writing.

If you have further questions or concerns, please contact our office.

**Medical Records Dept.**
**(626) 795-7051 Ext. 160**
**medicalrecords@hppgmail.com**

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Pasadena, CA 91105
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