Oak Park PEDIATRICS

AUTHORIZATION FOR MEDICAL RECORDS RELEASE

Patient Name_____ DOB_____

Doctor Office information
Doctor Name_____
Address _____
Phone #_____ Fax#_____
Patient treated at this office from _____(date) to _____(date)

Information to be released:
____ Hospital reports
____ History & Physical Exam
____ Lab/ X-ray reports
____ Consultation reports
____ Vaccination records
____ ALL MEDICAL RECORDS
Other (please specify): _____

I understand that this is a required consent and that I must voluntarily and knowingly sign this authorization BEFORE any records can be released, and that I may refuse to sign.

I further release my physician, the facility, and any Oak Park Pediatric employees from any liability arising from the release of information to the person designated above. I understand that I have the right to receive a copy of this authorization.

Signature of Parent/Guardian_____ Date_____
Relationship to Patient_____

Please send records attention to:
Andrew M. Matthew, M.D., Jessica M. Hochman, M.D. or Karen Tenenblatt, M.D.

Address
358 N. Kanan Road Phone 818-707-0046
Oak Park CA, 91377 Fax 818-707-2430