AUTHORIZATION TO RELEASE MEDICAL RECORDS

DATE: ___________________

PLEASE FORWARD MEDICAL RECORDS ON:

PATIENT'S NAME: ________________________________

BIRTHDATE:____________________________________

FROM:

THOUSAND OAKS PEDIATRICS
1000 Newbury Road, Suite 200
Newbury Park, CA 91362
PHONE: 805-480-3730
FAX: 805-480-1951

TO: ____

____

____

I understand that this may include information relating to mental or emotional diagnoses.

____
SIGNATURE (PARENT OR GUARDIAN, OR PATIENT IF OVER 18 YRS)

INCLUDE:

- **MENTAL HEALTH RECORDS**

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SIGNATURE (PARENT OR GUARDIAN)

- **SUBSTANCE ABUSE RECORDS**

____
SIGNATURE (PARENT OR GUARDIAN)

- **HIV/ STD TESTING RESULTS**

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SIGNATURE (PARENT OR GUARDIAN)