Please read carefully and complete the reverse side of this form.
All sections of this authorization must be completely filled out before Waring Court Pediatric and Adult Medical Group is permitted to disclose your protected health information.

Explanation: this form authorizes the use or disclosure of protected health information in the matter described below and is voluntary. Waring Court Pediatric and Adult Medical Group will still provide medical treatment for you or your children if you do not sign this authorization, except under limited circumstances that are described in our Notice of Privacy Practices. Please be aware that once you information leaves Waring Court Pediatric and Adult Medical Group, Waring Court Pediatric and Adult Medical Group will no longer be able to protect that information, and the recipients of your information may no longet be legally required to protect your information.

Authorization to Disclose Specific Protected Health Information: Federal and State laws require us to obtain specific authorization from patients to release especially sensitive information. Sensitive information is defined as treatment or documentation related to HIV and AIDS test results; Psychiatric care; and treatment for Alcohol or Drug Abuse. Be aware that we will automatically try to exclude these types of information unless you specifically identify them for release.

Restrictions: I understand that Waring Court Pediatric and Adult Medical Group may not further use or disclose the information described on the reverse side of this form unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. I hereby release Waring Court Pediatric and Adult Medical Group from any/all liability that may arise from the release of this information to the party name on the reverse side of this form.

Additional Copy: I Further understand that I have a right to receive a copy of this authorization upon my request.

Duration: I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken. Unless otherwise noted, this authorization will expire **one year** from the date of my signature.

Please complete the reverse side of this form

Waring Court Pediatric And Adult Medical Group
WCPAMG.COM

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1. Authorization : I authorize disclosure of medical information and health records as described below:

Name of Patient:_____ **Date of Birth** _____/_____/_____

last 4 of Social Security number: _____ **Telephone:** _____

2. Record Holder: _____

_____

3. Records May Be Released to: ***Waring Court Pediatric And Adult Medical Group***
3230 Waring Court, Suite J Oceanside, CA 92056
P) 760-941-4498 F) 760-941-6938

4. Type of Information: This authorization does not apply to the following type(s) of information unless my initials appear beside each applicable category.

	Psychiatric Records		Treatment for Alcohol and/or Drug Abuse
	HIV Test Results		Laboratory Tests
	Discharge Summary		Progress Notes
	History/ Physical Exam		Consultation Reports
	Radiology/ Nuclear Medicine Reports		Operative /Procedure Reports
	Emergency Department Reports		Billing Information

Other (Please Specify) _____

5. Dates of Service: From_____/_____/_____ **To** _____/_____/_____

6. Use of Information: The individual or entity identified above is permitted to use my information for the following purposes: ***Please initial all that apply***

	Continuing Medical Care		Second Opinion
	Personal		Insurance
	Legal		Audio/Visual Marketing
	Education Media		Print Marketing

Other (Please Specify)_____

7. Duration: This Authorization is Valid for one year from the date next to my signature otherwise noted here:

8. Signature:

Printed Name:_____ Signature_____ Date_____

If signed by other than patient, Indicate relationship to patient:_____

Witness Signature (*WCPAMG Representative*)_____ Date_____