



SURFSIDE PEDIATRICS
Dr. Kevin G. White M.D.
2601 E Main St, Ste 200
Ventura, CA 93003
Phone (805) 643-7500 Fax (805) 643-7510

AUTHORIZE FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

I hereby authorize: Surfside Pediatrics
 2601 E Main St Ste 200
 Ventura, CA 93003
 805-643-7500 phone, 805-643-7510 fax

To release information regarding my or my child's (if patient is a minor) medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider my hold, by means of mail, fax, or other electronic methods.

To: _____
 Physician/Healthcare Facility/Parent Name

 Address

 City ST Zip

 Phone Fax

The medical information/records will be used for the following purpose: _____

This authorization is:

- unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
- limited to the following medical information: _____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____ (initial) HIV Diagnosis/Treatment _____ (initial)
 Psychiatric/Mental Health _____ (initial) Genetic Information _____ (initial)
 Tests for Antibodies to HIV _____ (initial)

Patient name:	Date of birth: / /	Sex: <input type="checkbox"/> male <input type="checkbox"/> female
Patient name:	Date of birth: / /	Sex: <input type="checkbox"/> male <input type="checkbox"/> female
Patient name:	Date of birth: / /	Sex: <input type="checkbox"/> male <input type="checkbox"/> female

Signature _____

Relationship to minor mother father legal guardian _____

Date _____