SOUTH BASCOM PEDIATRICS, INC.
14601 S Bascom Ave, Suite 220
Los Gatos, CA 95032
Phone: 408-356-7770
Fax: 408-356-7774

Patricia A Ferrari, MD, PhD
Mary Beth Hughes, MD
Christianne Strickland, MD

This authorization for use or disclosure of my health information is required by state and federal law.

PATIENT'S NAME_____DOB:_____
LAST FIRST MI

Daytime Telephone Number_____

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF MY HEALTH INFORMATION FROM:

_____
Name of person or organization releasing information

_____
Street Address

_____
City State Zip Code

TO RELEASE MY HEALTH INFORMATION TO:

_____
Name of person or organization receiving information

_____
Street Address

_____
City State Zip Code

THIS RELEASE APPLIES TO THE FOLLOWING INFORMATION:
All records_____ Xrays_____ Immunizations____ Lab____
Other:_____

A SPECIFIC AUTHORIZATION IS REQUIED TO RELEASE INFORMATION REGARDING THE FOLLOWING:
HIV Information yes____ no____ Initials _____
Drug/Alcohol Information yes_____no____ Initials _____
Mental Health Information yes_____no____ Initials _____

THIS AUTHORIZATION SHALL BE VALID UNTIL_____. PLEASE INDICATE A DATE AFTER WHICH NO INFORMATION CAN BE RELEASED. If no date is given, authorization is valid for 90 days only.

I HAVE A RIGHT TO A COPY OF THIS AUTHORIZATION. COPY REQUESTED: YES___NO___

_____DATE_____
PATIENT/PARENT/LEGAL REPRESENTATIVE SIGNATURE

_____
RELATIONSHIP TO PATIENT