California Pediatric Surgical Group

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Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

The information you may release subject to this Release Form are as follows:

_____
_____
_____
_____

Release my protected health information to the following person(s)/entity:

Name:_____

Street:_____

City:_____State:_____Zip:_____

Patient Name:_____**DOB:**_____

Street:_____

City:_____**State:**_____**Zip:**_____