AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

A. EXPLANATION

This authorization is for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act 1981, Sec 56 et seq., California Civil Code.

B. AUTHORIZATION

I authorize Heart of the Valley Pediatric Cardiology to furnish and obtain requested information to the patient insurer, other health care facilities companies providing recommended medical equipment, and to other physicians or health care professionals for the purpose of mine or my child's care.

Child's Last Name First Name Middle

Address Street City State Zip

To whom you want the copies sent to:

Name

Address: _____

Date:_____

Signed:_____

Relationship to the patient:_____

*Please send copies of all medical records lab work, ultrasounds, X-Rays, Echocardiograms with reports.