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 _____
to furnish and obtain requested information to Heart of the Valley Pediatric Cardiology for the purpose of my or my child's care.

_____

Child's Last Name First Name Date of Birth

_____

Address Street City State Zip

Please send all medical records that are of importance to the cardiac care of this patient.

To whom you want the copies sent to:

Heart of the Valley Pediatric Cardiology
5933 Coronado Lane, Suite 104
Pleasanton, CA 94588

Date:_____

Signed:_____
Relationship to the patient

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