Huntington Plaza Pediatric Group

A Medical Group
800 S. Fairmount Ave. Suite 110
Pasadena, CA 91105
Phone: (626) 795-7051 Fax: (626) 795-1239

Audrey Reid, M.D., M.P.H., F.A.A.P.
Jennifer Cohen, M.D., F.A.A.P.
Francisco Rivera, M.D., F.A.A.P.
Sharon Wollaston, M.D., F.A.A.P.
Ruby Batin, M.D.

Please complete the attached medical release form & return it to our office at your earliest convenience. Please allow up to 1 week for your request to be processed. You may submit your request in person or by mail, fax, or email. Expiration of authorization effective immediately after request has been processed and completed.

New Patients: We will forward your request to your prior doctor's office. Please be sure to include the address & phone/fax number of the facility you are requesting records *from* or we will be unable to process your request.
Established Patients: If you are moving or switching doctors please include the address & phone/fax number of the doctor's office the records are being *forwarded* to. If this contact information is not included on the release form we will be unable to process your request.

HIPAA Compliant Authorization for the Release of Medical Records:

- The recipient of the protected health information under the authorization will not re-disclose the information, except with a written authorization or as specifically required or permitted by law.
- HPPG will not condition the provision of care or the receipt of benefits on the signing of the authorization.
- The patient will receive a copy of the completed authorization form upon request.
- The patient or patient's representative has the right to revoke authorizations in writing.

If you have further questions or concerns, please contact our office.

Huntington Plaza Pediatrics
Medical Records Department
(626) 795-7051 Ext. 127
medicalrecords@hppgmail.com

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Consent for Release of Medical Information

The authorization for use of medical information is being requested of you to comply with the requirements of California Civil Code Section 56, et seq.

Patient Name: _____ Date of Birth: _____

I Hereby Authorize:

Name of Healthcare Provider: _____
Address: _____
Phone: _____ Fax: _____

To Release My Medical Records & Request They Be Forwarded To:

Name: _____
Address: _____
Phone: _____ Fax: _____

Items To Be Copied:

_____Labs
_____X-rays
_____Consultation
_____Hospital / ER Report

_____ Immunization Record
_____ Standard Copy (Free)
_____ Standard Copy (Vaccine Record, Growth Chart, Most Recent Physical/Well Baby Exam)
Other _____

*Reason for Release of Medical Records: _____
(Continuing Care, Change of Insurance/Medical Coverage, Referral, etc.)

I understand that the requester or recipient of these medical records may not further use or disclose this protected health information unless another authorization is obtained or such use or disclosure is specifically required or permitted by law.

Date: _____ Signature: _____
(Patient or Representative)