WEST HILLS CHILDREN'S MEDICAL GROUP

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Authorization for Release of Medical Information

Patient's Name: _____ Date of Birth: _____

Signature of Parent/Guardian: _____ Date Requested: _____

I authorize West Hills Children's Medical Group to:

Release Medical Information to: _____
Name of Provider

_____
Address of Provider

_____
City/State/Zip Code of Provider

_____
Phone Number/Fax Number (Including area code)

OR

Requesting Medical Information from: _____
Name of Provider

_____
Address of Provider

_____
City/State/Zip Code of Provider

_____
Phone Number/Fax Number (Including area code)

This authorization is valid for 90 days