

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize: **Robert W. Sears, MD**
26933 Camino De Estrella, Suite A, Capistrano Beach, CA 92624
Phone: 949-230-7201 Fax: 949-493-0535

To release medical records to: _____

Address: _____

Phone: _____ Fax: _____

For records sent to Physicians, medical groups or hospitals, there is no charge. For records copied for personal use, there will be a \$25 fee.

Information to be released: _____ **All Records** _____ Vaccine Records _____ Growth Charts

_____ Most Recent Visit Specific dates: from _____ to _____

Limited to/Please include _____

Special Authorization: _____ Mental Health treatment _____ HIV test results _____ Alcohol/drug treatment

Purpose: _____ continuation of care _____ change of Dr _____ moving out of area _____ legal

Other _____

Patient Name _____ Patient Date of Birth _____

Address _____ Phone _____

Requestor _____ Relationship _____

Signature _____ Date _____

This authorization is effective now and will remain in effect for six months from the date signed or until _____.