Monterey Peninsula Pediatric Medical Group

2 Upper Ragsdale Dr, Suite B210, Monterey, CA 93940

Ph 831-333-0999 Fax 831-333-0909

Records In

Date: _____

Re: _____ DOB: _____

_____ DOB: _____

I hereby authorize:

_____

_____

_____

to furnish a copy of records – full detail including immunizations- of the medical care and treatment of the above named child/children to:

Monterey Peninsula Pediatric Medical Group

2 Upper Ragsdale Dr, Suite B210, Monterey, CA 93940

Ph 831-333-0999 Fax 831-333-0909

For the purpose of:

___specialist ___moving out of area ___change of insurance ___other

Parent/guardian signature: _____

Name:_____

Address: _____

_____

Phone # :_____

I understand that these records may indicate treatment for a psychiatric condition, alcohol or substance abuse, and/or HIV testing

___ok to release ___do not release ___not applicable

Parent/guardian signature: _____