MISSION Pediatrics™
WWW.MISSIONPEDIATRICS.COM

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) and/or medical entity named below to request confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcoholic/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

For the following date(s), _____-[ ] to Present, I hereby authorize the release of information regarding medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from other healthcare providers pertaining to

_____ with date of birth _____ that
(Patient Name) (Date of Birth)

_____ may hold, please remit by means of mail, fax, or
(Name of custodian of records)
other electronic methods that are HIPAA compliant to the physicians listed below at Mission Pediatrics, Inc.

To: **Mission Pediatrics, Inc.**

Timothy D. Watson, MD **Faize P. Mustafa-Infante, MD** **Edilberto L. Agas, MD**

☐ **Perris Office**
215 W. 4th Street
Perris, CA 92570
Phone: (951) 943-4751
Fax: (951) 657-3522

☐ **Riverside Office**
6926 Brockton Ave Ste. 6
Riverside, CA 92506
Phone: (951) 779-1670
Fax: (951) 779-1679

The medical information/records will be used for the following purpose:

[ ] Treatment [ ] Consultation [ ] Continuity of Care [ ] Other

This authorization is:

[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

[ ] Limited to the following medical information: _____

[ ] Limited to All **Hospital or Surgi-Center Discharge Summaries not to include any nursing notes** or ancillary information not recorded by a physician, physician assistant or nurse practitioner.

[ ] Limited to All lab, imaging, diagnostic information.

[ ] Please include growth charts, vaccine records, problem lists, relevant laboratory or diagnostic information and pending specialist referrals.

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____ (initial)
Psychiatric/Mental Health _____ (initial)
Test for Antibodies to HIV _____ (initial)
HIV Diagnosis/Treatment _____ (initial)
Genetic Information _____ (initial)

DURATION
This authorization shall be effective immediately and remain in effect for one year from the signature date below or until _____
Date

RESTRICTIONS
Permission for further use of disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____ _____
Signature of the patient, parent, *legal or Personal representative* Relationship *if other than patient*

_____ _____
Patient's Name (Print) Patient's Date of Birth

_____ _____
Witness Name/Signature Date