Central Valley Pediatrics

7011 N. Howard Street, Suite 106
Fresno, CA. 93720
Phone: 559-431-6600 Fax: 559-431-6106

AUTHORIZATION FOR TRANSFER OF RECORDS

Office/

Doctor:_____

_____

Address:_____

_____

Phone #: _____ Fax

#:_____

I hereby authorize _____ to

transfer all medical

information pertaining to patient:_____ Date of

Birth:_____

To: Central Valley Pediatrics, 7011 N. Howard Street, Suite 106, Fresno CA. 93720 records may include HIV test results.

Date of Request:_____

Print Name of Parent or Legal Guardian:

_____

Signature of Parent or Legal

Guardian:_____

Address:

_____

_____

Date: _____

CONFIDENTIAL COMMUNICATION
THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM CONFIDENTIAL RECORDS WHICH ARE PROTECTED BY STATE LAW. STATE LAW PROHIBITS YOU FROM MAKING FURTHER DISCLOSURES OF THIS INFORMATION WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY LAW. ANY UNAUTHORIZED FURTHER DISCLOSURE IN VIOLATION OF STATE LAW MAY RESULT IN A FINE OR JAIL SENTENCE OR BOTH. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT AUTHORIZATION FOR FURTHER DISCLOSURE. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE NOTIFY THE SENDER IMMEDIATELY BY TELEPHONE AND RETURN THE ORIGINAL COMMUNICATION TO US AT THE ABOVE ADDRESS BY THE U.S. POSTAL SERVICE. THANK YOU.