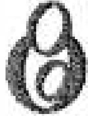

PEDIATRIC OFFICE OF M. ABUNTO, MD & M. TOLENTINO, MD
1001 SNEATH LANE, SUITE 104, SAN BRUNO, CA 94066
P (650)-873-4545 F (650)-873-4544

# AUTHORIZATION FOR TRANSFER OF MEDICAL RECORDS

PATIENT'S NAME : ______________________________ DATE OF BIRTH : ________

ADDRESS : ____________________________________ TEL : ______________

______________________________________________________________

I hereby authorize:

______________________________________________ (Name of doctor / office)
______________________________________________ (address)
to transfer and disclose my health information (medical records, including immunization records, laboratory results, radiology reports, consultation reports)to Dr Abunto and Dr Tolentino for the purpose of continuity of care.

DURATION : This authorization shall become effective immediately and shall remain in effect for one year.

REVOCATION : This authorization is subject to written revocation by me at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

REDISCLOSURE : I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Date : ___________ Signature : ______________________________

If signed by other than patient, indicate relationship : ______________

Name of representative : ______________________________________