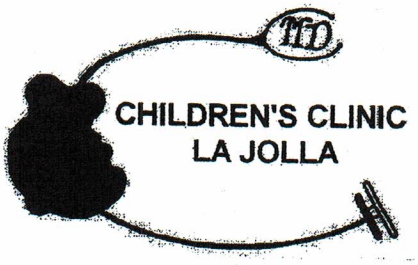

AUTHORIZATION TO RELEASE MEDICAL RECORDS

This authorization to release medical information is in accordance to the Confidentiality of Medical Act of 1981, Section 56 et seq. of the California Civil Code.

I hereby authorize:

Name_____ Phone(____)_____Fax(____)_____
(Previous Physician, Hospital, or Healthcare Provider)

Complete Address_____

To release my records to:
Children's Clinic La Jolla
5726 La Jolla Blvd, Suite 107
La Jolla, CA 92037
Phone (858)459-5437
Fax (858)459-5459

Please release **ALL MEDICAL INFORMATION** including diagnosis and records of any treatment or examination rendered to the following physician(s):_____, MD

Please: ___Fax the records ___Mail the records ___Have ready for pick-up___/___/___

Patient Name:_____ DOB_____/_____/_____

Sibling Name:_____ DOB_____/_____/_____

Sibling Name:_____ DOB_____/_____/_____

Authorized Signature:_____

Print Name:_____

Date:_____/_____/_____ ***This authorization is valid for one year from signature date.**