S. Daman Paul, MD
Gretchen Gainor, MD
Karen McGowan, MD
Alisa Lawrie, MD

5726 La Jolla Blvd. Sutie 107, La Jolla CA 92037
Phone: (858)459-5437 Fax: (858)459-5459

AUTHORIZATION TO RELASE HEALTHCARE INFORMATION

Patient's Name_____ DOB_____/_____/_____

Siblings Name_____ DOB_____/_____/_____

I request and authorize **Children's Clinic La Jolla 5726 La Jolla Blvd, #107, La Jolla, CA 92037** to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State:_____ Zip:_____

Reason for Release:

_____

This request and authorization applies to:

__Health information relating to the following treatment , condition, or dates: _____

_____

__All health care information: _____

__Other: _____

____Yes ____No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Parent/Guardian Signature: _____ Date:____/_____/_____

Parent Name: _____

M.D. Approval to Release Medical Record

_____