



Sea View Pediatrics

Serving Orange County Since 1973

A member of CHOC Children's Network

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Patient Authorization for Release (Disclosure) of Protected Health Information

By signing this Authorization, I authorize:

Previous Provider's Name: _____

Address: _____

Phone No: _____

Fax No: _____

To disclose the following individually identifiable health information

- () Immunizations Only
- () All Records for All Dates of Service
- () Other _____

Patient Name: _____

Patient Date of Birth: _____

The information will be used or disclosed for the following purpose:
Continued medical care of the patient.

This authorization expires: _____
Date

Signed by: _____
Signature of Patient or Legal Guardian Relationship to Patient

Print Legal Guardian's Name Today's Date

Patient or Legal Guardian's Phone No.