

Authorization to
Receive or Release
Medical Record
Information



Date: _____

To request release of medical information please complete and sign this form and return it to:

Bay Area Children's Association
20380 Town Center Lane Suite 215
Cupertino, CA 95014

Phone 408.996.7950
You may submit this form by Fax to: 408.996.7997

Patient Information

Patient Last Name _____ First Name _____ MI _____
Street Address _____ Apt# _____
City _____ State _____ Zip _____
Child's MR# _____ Telephone (Home) _____
Date of Birth _____ Telephone (Alt.) _____

Bay Area Children's Association has my permission to receive or release information (contained in the Medical Record or otherwise) of the above named patient.

Information Requested (please be specific and enter date of service if known):

Restrictions and/or Exclusions (if any):

Purpose of Release:

Bay Area Children's Association will receive or release information from/to the following party

Name _____
Attention of _____ Telephone _____
Street Address _____ Suite _____ Fax _____
City _____ State _____ Zip _____

I hereby authorize the Bay Area Children's Association (BACA) to receive or release any medical information as requested above. This may include information about drug or alcohol use, psychiatric, social work, or other protected information unless otherwise excluded, except psychotherapy notes. I am aware that BACA cannot control how the sender shares the information, and that laws protecting its confidentiality at BACA may or may not protect this information once it has been received.

Information will not be released without a valid signature below. This authorization will expire one year from the signature date. I can however, cancel this authorization in writing at any time, except to the extent that BACA has relied upon it. For example, if I cancel it after BACA has received records, BACA will not destroy those records. The authorization to release records can be canceled at any time by submitting a written request to BACA.

Patient Signature (if 18 years or older) _____ Date _____

Signature of Parent or Guardian (if minor patient) _____ Relationship to Patient _____ Date _____

Printed Name of Parent or Guardian: _____