AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize: ____
(Name of Physician, Medical Group or Hospital)

Address: ____

Phone: ______________________________ Fax: ______________________________

To release medical records to: **Robert W. Sears, MD**
26933 Camino De Estrella, Suite A, Capistrano Beach, CA 92624
Phone: 949-230-7201 Fax: 949-493-0535

Information to be released: _______**All Records** _______Vaccine Records _______Growth Charts

_______Most Recent Visit Specific dates: from_______________ to_______________

Limited to/Please include____

Special Authorization: _______Mental Health treatment _______ HIV test results _______Alcohol/drug treatment

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Purpose: _______continuation of care _______change of Dr _______moving out of area _______legal

Other____

Patient Name____ Patient Date of Birth____________________________

Address____ Phone______________________________

Requestor____ Relationship______________________________

Signature____ Date______________________________

This authorization is effective now and will remain in effect for six months from the date signed or until ______________.