Print Form

Walton Pediatrics

And Medical Associates, Inc.
7237 E. Southgate Drive Suite A
Sacramento, CA 95823
Phone: (916) 422-6635 Fax: (916) 422-2741

Scripps Pediatrics

1 Scripps Drive, Suite 107
Sacramento, CA 95825
Phone: (916) 929-3456 Fax: (916) 929-2812

Stephanie A. Walton, M.D., F.A.A.P - Medical Director

RECORD RELEASE AUTHORIZATION

( ) REQUESTING TO INSPECT AND COPY PROTECTED HEALTH INFORMATION:

YOU HAVE THE RIGHT TO REQUEST, TO INSPECT PROTECTED HEALTH INFORMATION IN RECORDS WHICH *WALTON PEDIATRICS/SCRIPPS PEDIATRICS* CREATES OR MAINTAINS. YOU ALSO HAVE THE RIGHT TO REQUEST COPIES OF THOSE RECORDS. YOU MAY BE CHARGED FOR THE COST OF COPYING AND POSTAGE. YOU WILL RECEIVE A RESPONSE TO YOUR REQUEST WITHIN 30 DAYS AFTER WE RECEIVE YOUR CALIFORNIA DRIVER'S LICENSE/IDENTIFICATION CARD ISSUED BY THE DEPARTMENT OF MOTOR VEHICLES OR OTHER VALID INDENTIFICATION. YOU WILL NEED TO SEND DOCUMENTATION VERIFYING YOUR ADDRESS.
MAIL THIS COMPLETED FORM TO

ATTENTION: [ ] THE HIPPA COMPLIANCE DESK
WALTON PEDIATRICS
7237 E. SOUTHGATE DRIVE, SUITE A
SACRAMENTO, CA 95823

ATTENTION: [ ] THE HIPPA COMPLIANCE DESK
SCRIPPS PEDIATRICS
1 SCRIPPS DRIVE, SUITE 107
SACRAMENTO, CA 95825

( ) I AM REQUESTING THE PROVIDER LISTED BELOW, TO SEND MY CHILD'S MEDICAL RECORDS TO WALTON PEDIATRICS AND MEDICAL ASSOCIATES, INC./ SCRIPPS PEDIATRICS

( ) I AM AUTHORIZING WALTON PEDIATRICS AND MEDICAL ASSOCIATES, INC./ SCRIPPS PEDIATRICS TO SEND MY CHILD'S MEDICAL RECORDS TO THE PROVIDER LISTED BELOW.

_____
NAME OF DOCTOR OR GROUP

_____
ADDRESS

_____
CITY STATE ZIP

( ) _____ ( ) _____
PHONE NUMBER FAX NUMBER

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____

Address: _____
Street Apt #

_____
City State Zip

PARENT, GUARDIAN, OR LEGAL REPRESENTATIVE INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____

Address: _____
Street Apt #

_____
City State Zip

Phone Number: ( ) _____- _____

Signature: _____ Date: _____

(continue on back)

WHAT LEGAL AUTHORITY DO YOU HAVE TO REQUEST THE HEALTH INFORMATION FOR THE PATIENT ABOVE? :

(☐) PARENT (☐) GUARDIAN (☐) MEDICAL POWER OF ATTORNEY (☐) OTHER

WHAT TYPE OF PROTECTED HEALTH INFORMATION DO YOU WANT TO ACCESS? :

(☐) IMMUNIZATION RECORDS (☐) COMPLETE MEDICAL RECORDS

(☐) OTHER (SPECIFY): _____

METHOD TO ACCESS REQUESTED HEALTH INFORMATION:

(☐) PLEASE FAX THE REQUESTED INFORMATION TO: *WALTON PEDIATRICS - FAX: (916) 422-2741 OR SCRIPPS PEDIATRICS: FAX: (916) 929-2812*

(☐) PLEASE MAIL A COPY OF THE REQUESTED INFORMATION TO THE ADDRESS INDICATED.

(☐) I WISH TO REVIEW THE REQUESTED INFORMATION IN PERSON

I UNDERSTAND AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR ANY FEES ASSOCIATE WITH MY REQUEST, COPYING CHARGES, INCLUDING THE COST OF SUPPLIES, LABOR, AND POSTAGE RELATED TO THE PRODUCTION OF MY INFORMATION.

CHARGE FOR THIS SERVICE: $ _____

THIS AUTHORIZATION WILL REMAIN IN EFFECT FOR A 180 DAYS

I DECLARE UNDER PENALTY OR PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT

_____ _____

Signature of Parent or Legal Representative **Date**

_____

Print Name

FOR INTERNAL PURPOSES ONLY:

TYPE OF IDENTIFICATION ATTACHED: _____