Sutcliffe Developmental & Behavioral Pediatrics

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

851 Fremont Avenue, Suite 110
Los Altos, CA 94024

Child's Name: Child's DOB:

Guardian Name Guardian Phone:

I request and authorize Sutcliffe Developmental and Behavioral Pediatrics to release and exchange confidential information with the following entity:

Provider Name

Office Address

Office Phone:

Office Fax:

This request and authorization applies to:

- [x] All medical health records. *** Please send most recent notes (WCC, specialty) and patient's growth charts
- [x] All mental health and psychiatry records.
- [ ] Lab and radiology reports.
- [ ] Consultation notes or departmental reports:
- [ ] Healthcare information relating to the following treatment, condition, or dates:
- [ ] Other:

I authorize the release of any records regarding psychiatric treatment to the patient listed above.

Patient Signature: Date Signed:

Guardian Signature: Date Signed:

This authorization will expire one (1) year from the date signed or on unless otherwise revoked. To submit a revocation of the document, send the formal request to Sutcliffe Developmental and Behavioral Pediatrics, 851 Fremont Street, Suite 110, Los Altos, CA 94024.

When you have completed the form, please email the signed document back to info@sutcliffedbp.com

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You have a right to a completed copy of this authorization and can be provided upon request.