



**Capitola Pediatrics**  
 Infants . Children . Adolescents  
 4145 Clares Street, Suite A  
 Capitola, California 95010  
 831-476-1933

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

I, \_\_\_\_\_, hereby, authorize the release of information about  
 (Parent/Guardian)  
 myself/and or my child(ren): \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Between Capitola Pediatrics and (please indicate agency or professional):

Release records to: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

This authorization is:

- Single page (lab result, single chart note) – No charge**
- All growth charts, immunization records, medical summary and lab summary – \$10.00 fee**
- Entire chart (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment) - \$30.00 fee**

**The fee must be paid prior to the release of records, for each child. Please include payment with the release for medical records to ensure prompt processing of your child's records.**

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse	_____	(initial)
Psychiatric/Mental Health	_____	(initial)
Test for Antibodies to HIV	_____	(initial)
HIV Diagnosis/Treatment	_____	(initial)

This authorization expires on \_\_\_\_\_  
 Date (not to exceed 12 months)

\_\_\_\_\_  
 Patient Name (PRINT)

\_\_\_\_\_  
 Patient Date of Birth

\_\_\_\_\_  
 Signature (Parent/Guardian)

\_\_\_\_\_  
 Date