Royal
KIDS
Pediatric Clinic

RELEASE OF MEDICAL INFORMATION

Patient Name: _____Date of Birth: _____
Gender: Male Female
Address: _____
Home Phone: _____ Cell Phone: _____

I HEREBY AUTHORIZE RELEASE OF MY CHILD'S FOLLOWING HEALTH INFORMATION

- Rx(Prescription) History

- Immunization History
  FROM: Surescripts(External Database) and CAIRS(Immunization registry)
  TO: ROYALKIDS CLINIC
  18, Endeavor, Suite 203, Irvine, Ca, 92618
  Phone: 949-910-3457 Fax: 855-618-2214
  AND
  Record of all Immunizations given at ROYALKIDS CLINIC
  TO: CAIRS(Immunization registry) and OC Childrens screening Registry

- I understand that I have a right to revoke this authorization at any time, provided the Information has not been released. I understand that if I revoke this authorization, I must do so in writing and present my written and signed revocation to ROYALKIDS CLINIC . My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance on this authorization.

- I understand that authorizing the disclosure of this health information is voluntary. Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

Patient/Legal Representative (Print Name):_____
Patient/Legal Representative Signature: _____
Date:_____Time:_____AM/PM
If signed by other than patient, indicate relationship to patient:_____
Witness: _____Date:_____Time: _____ AM/PM