

# Mountain View Pediatrics

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## Transfer of Records

### AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL MEDICAL INFORMATION INCLUDING HIV RELATED INFORMATION

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Period of Time: From: \_\_\_\_\_ To: \_\_\_\_\_

Reason for Release: \_\_\_\_\_

Release of Information To: \_\_\_\_\_

\_\_\_\_\_

From: \_\_\_\_\_

\_\_\_\_\_

**I authorize Mountain View Pediatrics to \_\_\_ Obtain \_\_\_ Release medical records, x-ray films, x-ray reports, and other information regarding the hospitalization, and/or outpatient care concerning the above named patient for the period specified. This authorization includes confidential information such as: psychological or psychiatric impairment, drug use and/or alcoholism, Acquired Immunodeficiency Syndrome (AIDS) and test for or infection with Human Immunodeficiency Virus (HIV).**

**I understand that this authorization will automatically expire six (6) months from the date below; unless otherwise specified.**

X \_\_\_\_\_  
Signature of Patient (or person  
authorized to consent for patient)

X \_\_\_\_\_  
Date

X \_\_\_\_\_  
Relationship to patient

X \_\_\_\_\_  
Witness

Staff: Request completed by- Initials and date \_\_\_\_\_