CPMG AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL RECORDS

This authorization allows the healthcare provider(s) named below to release confidential and non-confidential medical records. Note: *Information and records regarding treatment of minors, HIV, psychiatric / mental health conditions, or alcohol / substance abuse have special rules that require specific authorization.* Coastal Pediatric Medical Group "CPMG" refers to *all of our providers and staff.* **You may revoke authorization at any time verbally or in writing.** Records received by one office may be moved between offices physically or electronically as needed. A copy of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization. Please complete this form as well as you can today. Rev 1/6/2026

I am the patient or parent or legal guardian of the child listed below and I authorize the providers listed below to send or release information for **NAME: _____ DOB _____** regarding medical history, illness, injury, consultation, prescriptions, treatment, diagnosis, prognosis, x-rays, correspondence and/or medical records including those from other health care providers, by means of mail, fax, or other electronic methods.

_____ (initial) I AUTHORIZE **CPMG TO SEND RECORDS** TO THE FOLLOWING PERSON(S) OR OFFICE::

Name: _____

Phone: _____ Fax: _____

_____ (initial) I AUTHORIZE OTHER PROVIDERS (LISTED BELOW) TO **SEND RECORDS TO CPMG:**:

Name: _____

Phone: _____ Fax: _____

** ***PLEASE CIRCLE THE OFFICE WHERE RECORDS ARE TO BE SENT*** **

VENTURA CPMG: 100 N Brent St. Ste 102, Ventura, CA 93003 PHONE: 805-643-9271 FAX: 805-643-6717

OR

OXNARD CPMG: 451 W Gonzales Rd. Ste 340, Oxnard, CA 93036 PHONE: 805-983-3900 FAX: 805-983-3887

Coastal Pediatric Medical Group is requesting the following records:

____ **ONLY: Immunization record, Growth Charts, Problem List, and _____ .**

____ All records related to the date(s) of service: _____ or the following condition(s): _____

**** PLEASE MAIL IF RECORDS ARE LONGER THAN 30 PAGES! **** Thank you.

____ NO MEDICAL RECORDS NEEDED AT THIS TIME. This release is being signed so that care providers at both our office and yours can communicate verbally about ongoing care. Please call us to discuss patient care anytime.

PURPOSE: This authorization shall be used for medical care, transfer of care, referrals, or: _____.

DURATION: This authorization shall be effective immediately and remain in effect until it is revoked or: _____.

RESTRICTIONS: Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

SCOPE: This authorization is: [ ] UNLIMITED

[ ] Limited to the following medical information: _____

I consent for specific authorization of the following confidential records: Genetic Information _____ (initial)

Alcohol/Substance Abuse _____ (initial) Psychiatric/Mental Health _____ (initial)

Tests for Antibodies to HIV _____ (initial) HIV Diagnosis/Treatment _____ (initial)

PARENT / GUARDIAN / ADULT PATIENT **SIGN HERE:**

Parent, guardian, or legal representative signature: _____ Date: _____

Parent, guardian, or legal representative name: _____