david w. kittams, m.d., (retired)
robin f. winokur, m.d., f.a.a.p.
elizabeth l. salsburg, m.d., f.a.a.p.
nanci tucker, m.d., f.a.a.p.
benjamin jarrahi, m.d., f.a.a.p.
mark thomas, p.n.p.
erin shuster, p.n.p.

1744 alcatraz avenue
berkeley, california 94703
phone: 510/652-1720
fax: 510/652-2624

1178 san pablo avenue
berkeley, california 94706
phone: 510/524-9400
fax: 510/524-9470

www.kiwipediatrics.com
email: kiwioffice@gmail.com

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT:_____**BIRTHDATE**:_____
PATIENT:_____**BIRTHDATE**:_____

I authorize the following healthcare provider/facility to release protected health information to Kiwi Pediatrics Medical Group, Inc..

Name:_____
Address:_____
_____

This authorization applies to the following information unless otherwise stated:
Problem List, Current Medications, Pertinent Medication History, Immunizations, Growth Records (growth charts), Pertinent Diagnostic Studies, Pertinent Consultations

- *I understand the information in the health record may include information relating to sexually transmitted disease, including HIV, It may also include information about behavioral/mental health and drug or alchohol abuse.*
- Other:_____

From (check which applies): ☐ all dates of service ☐ dates:_____

This health information is requested by the patient/patient representative for the purpose of ongoing care unless otherwise stated here:_____.

Kiwi Pediatrics is required by law to keep your health information confidential. This authorization to release health information is VOLUNTARY and may be revoked at any time. The revocation will take effect when Kiwi Pediatrics receives it. I understand that treatment, payment, or eligibility for benefits will not be affected if I do not sign this authorization.

Redisclosure: California law prohibits the entity receiving this health information from further disclosure without appropriate authorization unless specifically required or allowed by law.

Expiration of Authorization: Unless otherwise revoked, the authorization will expire 12 months after the date of my signing this form or on the following date:_____

I have the right to receive a copy of this authorization and the health information being disclosed.

_____ _____ _____
print name **signature** **date**