Dafna Ahdoot MD FAAP
17200 Ventura Blvd Suite 212, Encino CA 91316
(P) 818-208-2626 (P) 855-DR-DAFNA (F) 818-208-3434
info@milkandhoneypeds.com

MEDICAL RECORDS REQUEST

I hereby authorize:

Physician Name:_____

Address: _____

Phone Number:_____ Fax Number: _____

To release the immunization record, growth chart, last physical, and any specialist evaluations, for my child listed below via **fax at 818-208-3434** or mail them to Milk and Honey Pediatrics, 17200 Ventura Blvd Suite 212, Encino, CA 91316.

Patient Name: _____DOB: _____
FIRST AND LAST MM/DD/YYYY

Records will be released to:
Milk and Honey Pediatrics, Dafna Ahdoot MD, FAAP

The medical information will be used for the following purpose:
☐ Dr. Review ☐ Insurance Review ☐ Other: _____
This authorization is for:
☐ **All Records** (excluding substance abuse, mental health, HIV Diagnosis/Treatment)
☐ Limited to the following medical information: _____
I also consent to the specific release of the following records:
☐ Drug/Alcohol/Substance Abuse ☐ Tests for Antibodies to HIV
☐ Psychiatric/Mental Health ☐ HIV Diagnosis/Treatment

Duration: This authorization is effective from _____ until _____
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.

A photocopy, e-mail, or facsimile of this authorization shall be considered as effective and valid as the original.

Parent/Guardian Name: _____

Parent/Guardian Signature: X _____

Date: _____