Sage Pediatrics - Amy Maidenberg, MD
4329 Piedmont Ave
Oakland, CA 94610

AUTHORIZATION FOR USE
AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth___/___/_____

I authorize (Name and address of provider):
_____
_____
_____

to release to (Name and address of recipient):
Sage Pediatrics -- Amy Maidenberg, MD
4329 Piedmont Ave, Oakland, CA 94610
Fax: 888.844.4383

the following health information:
- ☐ Complete Medical Record
- ☐ Immunization Records
- ☐ Laboratory Tests
- ☐ Radiology Reports

Please include restricted access information relating to (initial if needed):
_____ HIV test results _____ Behavioral Health _____ Genetic Testing

EXPIRATION: This authorization shall become effective immediately and will be valid for one year from the date of signing.

SIGNATURE:
_____
Signature (Patient/Representative)

PRINT NAME:
_____

Relationship to patient: _____

Date: ___/___/_____