AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider named below to release confidential medical information and records.

I hereby authorize Joshua Mandelberg, M.D., F.A.A.P of 11835 W. Olympic Blvd. Suite 1200E, Los Angeles, CA 90064, to release and receive information regarding my child’s medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax, or other electronic methods. This release includes psychiatric and/or mental health records. I give this authorization voluntarily and can revoke authorization in writing at any time.

This information may be released to/ received from: Other health professionals and educators (with expressed consent) who contribute to my child’s care. This information is to be used for planning my child’s care and treatment. This release can be revoked in writing at any time.  
  
**Exceptions:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child’s Name:**

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|  |  | |
| **Parent/Guardian Signature** | | **Date** |
|  |  | |
| **Parent/Guardian Name (Please Print)** | | |