Hue Nguyen-Ngo, D.O.
Nicole A. Shelton MSHS, PA-C

831-630-1477 or 831-313-0496
831-313-0291
Info@Hollisterpediatrics.com
930 Sunnyslope Road Suite E3 Hollister, CA 95023

I, ____, hereby
Print Parent/ Guardian Name (Nombre Del Padre/ Guardián)

authorize ____ to
Name Of Previous Doctor/Clinic and Phone Number (Nombre De La Clinica Anterior y Telefono)

release ____’s medical
Patient’s Name and DOB (Nombre Del Paciente y Fecha De Nacimiento)

record to disclose to:

Doctor/Hospital: Hollister Pediatrics
Address: 930 Sunnyslope RD E-3
City, State, Zip: Hollister, Ca 95023
Phone: 831-630-1477 Fax: 831-313-0291
Purpose: Continuity of Care

Please Include:

___X___ Shot Records ___X___ Labs/X-Rays ___X___ Hospital Discharge Summary

___X___ Problem List or Significant Other Medical History ___X___ Last Physical

____ ____
Parent Signature Date

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here:___________. Revocation: This authorization is also subject to written revocation by the member patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization. Disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.