



## Authorization for Transfer of Medical Records

I hereby authorize \_\_\_\_\_ to provide a copy of all medical  
Record information of my minor child or guardian, \_\_\_\_\_,  
date of birth \_\_\_\_\_ to Dr. Steven Martel and Oded Herbsman at:

**Child's Light Pediatrics, Inc.**  
**123 10<sup>th</sup> Street**  
**San Francisco, CA 94103**  
**415.265.5405**  
**866.910.0662 (f)**

Any and all information may be transferred, including, but not limited to mental health records, drug and alcohol abuse history, psychosocial information and/or HIV test results, if applicable, except as specifically provided below:

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\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship