Authorization for Disclosure of Health Information

Patient Name:_____

Date of Birth:_____Phone:_____

Address:_____

City:_____State:_____Zip:_____

I authorize the release of my child's health information from previous doctor's office:

Desert Shores Pediatrics, PC
6285 S Higley Rd Gilbert, AZ 85298 and/or 965 W. Chandler Heights Chandler, AZ 85248
Phone (480) 460-4949/ Fax (480) 460-5858

The type and amount of information to be used to be disclosed is as follows: (include dates where appropriate):

____Complete health records ____Lab results/ X-ray reports

____Physical exam ____Consultation reports

____Immunization records ____Other (Please specify):_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

This information may be disclosed to :

Name:_____ **Phone:**_____

Address:_____ **City,State:**_____ **Zip:**_____

For the purpose of: Medical Care

_____ I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition

_____ If I fail to specify an expiration date, event or condition, this authorization will expire in sixty days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign the authorization. I need not to sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules

_____ I understand that there is no cost to me for requesting to send medical records to another medical facility. I understand that if I want a copy of medical records for personal use, there may be a fee associated with this request and I agree to be responsible for that charge.

Are you leaving Desert Shores Pediatrics? ◯Yes ◯No

Purpose of Records Request:_____

_____ _____ _____
Signature of Patient or Legal Guardian Relationship to Patient Date

Please Note: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC-3701.243 and federal law 42 CFR, part II.