



Authorization for Disclosure of Health Information

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

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

Practice Name: Desert Shores Pediatrics

Address: 6285 S Higley Rd.

City: Gilbert State: Arizona Zip: 85298

2. 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): _____

3. 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.

4. This information may be disclosed to :

Name: _____ Phone: _____

Address: _____ City: _____ Zip: _____

For the purpose of: Medical Care

5. 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: _____

6. 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. _____

Are you leaving Desert Shores Pediatrics? Yes No

Purpose for records: _____

Signature of Patient of legal representative

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).

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