Authorization for Disclosure of Health Information

Patient Name:____ Date of Birth:____/____/____ Sex: M F

Address:____City:_______________________State:__________Zip:__________

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

Practice Name:____ Phone:______________________Fax:____________________

Address:____City:______________________State:__________Zip:__________

- **PLEASE SEND ONLY THE FOLLOWING, AS APPLICABLE:**

  - ✓ Patient Summary Page
  - ✓ Last 2 Wellness Visits
  - ✓ Growth Charts
  - ✓ Immunization Record
  - ✓ Labs and Diagnostic Imaging Reports
  - ✓ Most Recent Specialist(s) Visit Report(s)

  - **NEWBORN HOSPITAL RECORDS**: H&P, Discharge summary, pertinent labs/imaging/specialist notes
    PLEASE DO NOT SEND NURSING NOTES OR VITAL CHARTS
  - **Other (as written in)**:

- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency (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:	Desert Shores Pediatrics
Address:	6285 S. Higley Rd.
	Gilbert, Arizona 85298
Fax:	480-460-5858

For the purpose of: Medical Care

- I understand that I have a 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 this 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 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.

_____________________________________ _______________________ _________________

Signature of Patient or 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 is pertains or as permitted by state law (ORC-3701.243) and federal law 42 CFR, part II.