Authorization for Disclosure of Health Information (Outgoing Records)

Select Request & Note Fees: _____ Directly to another Healthcare Provider/Medical Facility – FREE.

_____ Patient Portal – FREE – print at home 24/7. Call for access if not enabled.

_____ Encrypted Email or _____ Thumb Drive - $6.50 flat fee plus postage (if applies).

_____ Paper Copies: maximum of $50 plus postage (if applies).

***** Payment (if any due) is required prior to pick-up or mailing *****

Patient Name: _____ DOB:_____

Phone: _____ Address: _____

City: _____ State: _____ Zip:_____

Authorization to Release From: Desert Shores Pediatrics, PC

Authorization to Release To: Name/Facility:_____

Phone: _____ Fax: _____

Address:_____

City: _____ State: _____ Zip:_____

Email address (if applicable): _____

Information to Release: _____ Medical Summary, Growth Chart, Immunizations, Labs, & Imaging

_____ Immunizations only _____ Medical Summary only _____ Labs/Imaging only

_____ Specific Office Visit (list dates):_____

_____ Specialist Report (list specialist, appt date):_____

_____ Other (specify): _____

_____ Complete Health Record

- I understand information in my health record may include information relating to sexually transmitted infections (STI), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment, including alcohol and drug abuse.
- 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 re-disclosure and the information may not be protected by federal confidentiality rule. Exp date (optional):_____
- 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 will be a fee associated with this request and I agree to be responsible for that charge.

Leaving Desert Shores Pediatrics: Y N Purpose of Records Release:_____

Signature:_____ Date: _____

Printed Name: _____ Relation to patient:_____

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 (42CFR, part II).