5425 East Bell Road Ste#131 Scottsdale, Arizona 85254
Phone: 602-374-3396 Fax: 602-374-3177
www.kidshealthpediatrics.com

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________ Date of Birth: ______________
Address: ______________________ Phone: ______________

From: **Office Name**: ______________________
Doctor's Name: ______________________
Address: ______________________
____
Phone: ______________________
Fax: ______________________

To release a copy of the following information: Entire Chart including: Immunization Records, Growth chart, and Labs

To: **KIDS HEALTH PEDIATRICS**
5425 E Bell Rd Ste#131
Scottsdale, AZ 85254
Phone: 602-374-3396
Fax: 602-374-3177

[x] For the following purposes: Ongoing medical care
[x] By the following method: [x] Mail [x] Fax

Medical records may include confidential information related to HIV, communicable disease, alcohol or drug abuse, and mental health diagnosis and treatment.
I [ ] do [ ] **DO NOT** authorize the release of this type of information.

I understand:

- I may revoke this authorization except to the extent that it has already been acted upon.
- Treatment will not be conditioned on my providing this authorization unless the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- Once this information is released it may be re-disclosed by the recipient and may no longer be protected information.
- I may have a signed copy of this authorization

______________________ ______________
Patient or Personal Representative's Signature Date

____
Description of Representative's Authority to Act for Patient

This authorization will expire on ______________________ (list date or event)