Desert Pediatrics

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This request to RELEASE medical records will be returned if not completed in its entirety.

Patient Name: _____ Medical Record Number: _____

Address: _____ City: _____ State: ____ Zip: _____ DOB: _____

I AUTHORIZE THE USE OR DISCLOSURE OF THE ABOVE NAMED INDIVIDUAL'S PROTECTED HEALTH INFORMATION AS DESCRIBED BELOW:

1. The type and amount of information to be used or disclosed is as follows
Include dates where appropriate: **FROM** (date) **THROUGH** (date)

☐ Entire Record, or: [ ] Medication List [ ] Immunization Record [ ] Provider Notes

[ ] Laboratory Results [ ] X Ray/Dexa Reports [ ]Consult Notes

[ ] Other _____

2. Please initial for release of the following information even if you checked "Entire Record" above.

_____ Psychiatric / Mental Health Information _____HIV Information _____ Addictive Behavior
_____ Child & Domestic Abuse History _____ Genetic Test Results
_____ Communicable & Sexually Transmitted Diseases

NOTE: INFORMATION PERTAINING TO SUBSTANCE ABUSE DIAGNOSIS OR TREATMENT REQUIRES COMPLETION OF THE CONSENT FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION UNDER 42 C.F.R. PART 2- CONFIDENTIATLITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS.

3. REASON FOR REQUEST: (PLEASE CHECK ONE)

☐ Medical Care ☐ Insurance ☐ Personal ☐ Attorney ☐ Other _____

4. 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 Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____

5. THIS INFORMATION IS TO BE DISCLOSED TO ☐ Requestor ☐ the following individual or organization

Name Phone Number Fax Number

Address City, State, Zip

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign the form in order to assure treatment. I understand that I may inspect or obtain a copy of 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. If I have questions about disclosure of my health information, I can contact the Health Information Management Department and obtain a copy of the Privacy Notice.

7. I wish to receive this information on ☐ Paper ($ .60 per page) ☐ CD, as a PDF file ($20.00)

Signature of Patient: _____ Date : _____

Signature of Parent, Guardian or
Personal Representative: _____ Date: _____

NOTE: PLEASE ALLOW 7 -10 BUSINESS DAYS from date of receipt by HIM Dept FOR PROCESSING.