Authorization For Release Of Health Care Information

1. Patient's Name: ____
2. Patient's Date of Birth: ____

3. Patient's Address: ____
____
____

Phone # ____________________________

Records being Requested From Address : ____

____

____

Phone # ___________________________ Fax # ______________________________

4. Please Release Records to Address

Desert Canyon Pediatrics P.C
3805 E. Bell Road, Suite 5100
Phoenix, Arizona 85032
Phone # 602-923-7730
Fax # 602-923-7833

5. Health records being requested:____
6. Purpose of Disclosure: ____

I the Undersigned do herby authorize and consent to the disclosure by **Desert Canyon Pediatrics** to the above named company or persons, or both, of any end all health records, documents, reports, clinical abstracts, of every kind and description, including substance abuse records, relating to my/my child's care, and treatment at said physicians office during the above period (s), and consent to the inspection and copying of the same

This authorization shall remain in effect for ninety (90) days from the date executed unless revoked earlier by me . If revoked earlier, all parties understand that information released prior to being notified of such revocation was made at my request and with my consent.

In furtherance of this authorization, I do hereby waive all provision of law and privileges relating to the disclosures hereby authorized.

I have read the above and foregoing Authorization for Release of Health Care Information, and I do hereby acknowledge that I understand the terms and conditions of this authorization.

Prohibition of Redisclosure

" This information has been disclosed to you from records protected by federal confidentiality rules (42CFR Part 2). The federal rule prohibit you form making any further disclosure to this information **unless further disclosure is expressly permitted by the written consent of the person** to who it pertains or as Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol drug abuse patient"

8. Patient Signature: ____ Date: ___________
9. Legal Guardian Signature :____ Date: ___________
10. Relationship to Patient : ____ Date:___________