POR FAVOR NO DUDE EN PREGUNTAR AL PERSONAL POR ASISTENCIA PARA LLENAR ESTE FORMULARIO

Authorization for Disclosure of Health Information

Patient Name: _____ Date of Birth: _____ ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

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

Practice/Hospital Name: _____ Doctor: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

2. The type and amount of information to be disclosed is as follows: *(include dates where appropriate)*

☐ Complete health records ☐ Lab results/ X-ray reports

☐ Physical exam ☐ Consultation reports

☐ Immunization records ☐ Other (specify): _____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

4. This information may be disclosed to: Name: **Yavapai Pediatrics**
Address: **3001 Main Street, Suite 1C**
Prescott Valley, AZ 86314
Fax#: **(928) 458-5979**

For the purpose of: Medical Care (I understand that the above named provider is covered by the federal privacy regulations (HIPAA) and is bound by law to only use the information received for only purposes listed).

5. 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 in 12 months from date of signature.

6. 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 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.

_____ _____ _____

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.

Cultivando Vidas Sanas!
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