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AUTHORIZATION TO REQUEST OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name: _____ Date of Birth:_____
Last First Middle

Name of parent/Legal Guardian:_____ Relationship to Patient:_____

Home Number:_____ Work/Cell:_____

By signing this form, I authorize PEDIATRICS OF QUEEN CREEK to (check one):

☐ **request** records **from** facility below the protected health information regarding patient above.
☐ **send** records **to** the facility below the protected health information regarding patient above.

Name of Physician/Facility:_____

Facility Address:_____

City, State, Zip_____

Phone:_____ **Fax:** _____

Reason for Request:_____

PLEASE NOTE IT MAY TAKE UP TO TWO WEEKS TO RECEIVE MEDICAL RECORDS

This authorization applies to the individual described above. Only the checked information will be disclosed in this authorization.

☐ **ALL AVAILABLE MEDICAL RECORDS**

☐ **ONLY INFORMATION PERTAINING TO THE FOLLOWING:**_____

☐ **IMMUNIZATION RECORDS ONLY**

_____ **Date:** _____
Signature of Parent/Legal Guardian

_____
Witness

This authorization will expire **1 year** from the date it was signed unless otherwise requested.

☐ **PARENT REQUEST FOR RECORDS? Y____**
☐ **REQUEST TO TRANSFER TO ANOTHER PROVIDER? Y____**
IF REQUESTING RECORDS FOR YOUR PERSONAL USE, WE CHARGE AS FOLLOWS FOR THE PREPARATION AND PRINTING OF THE RECORDS:
UP TO 50 PAGES IS .50 CENTS PER PAGE.
ANYTHING OVER 50 PAGES IS $25 PLUS .25 CENTS FOR EACH ADDITIONAL PAGE.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, AIDS or HIV, and alcohol and drug abuse. I authorize the release or disclosure of this type of information. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. The information released in response to authorization may be re-disclosed to other parties. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.