Pediatrics

"TLC for your kids."

Release and Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ **Date of Birth:** _____

Address: _____

Telephone: _____

I authorize **TLC Pediatrics** to disclose / receive the following information:

___Standard Electronic Medical Record Includes: Vaccines, Growth Chart, Problem List, Recent Labs & Recent Office Visits

___Specific record/information as follows: _____

___Other: _____

Purpose of disclosure: _____ Switching Providers (no charge) ***Immunizations will be faxed & records will be mailed***

_____ Personal Use (fee applies) ***Can be mailed or picked up, we cannot email medical information***

Release information (circle one) TO / FROM:

Address: _____

_____

Telephone: _____ **Fax:** _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that I have the right to inspect and receive a copy of the health information. I hereby authorize the release of photocopies of my medical records in procession and control of TLC Pediatrics. Medical Records shall include all confidential HIV related information (A.R.S. Section 35-6511): communicable disease related information (A.R.S. Section 36-651): confidential alcohol and drug abuse related information (42CRF Section 2.1et al) and confidential mental health diagnosis treatment information unless otherwise directed by me. I may revoke this Authorization by notifying the disclosing medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed Name of Patient or Personal Representative Relationship to patient

A photocopy or scan of this authorization shall be considered as effective and valid as the original for 1 year from date signed

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