Desert Valley Pediatrics

☐ West Valley Office
4137 N. 108th Ave.
Phoenix, AZ 85037
P 623-877-7337
F 623-772-0686

☐ At The Ball Park
3802 N. 53rd Ave. Ste. 160
Phoenix, AZ 85031
P 623-247-0883
F 623-247-6537

☐ Surprise Office
15264 W. Brookside Ln. Ste. 155
Surprise, AZ 85374
P 623-877-7337
F 623-214-3219

Authorization for Release of Health Information

Patient Name: _____ **DOB:** ____/____/____

1. I authorize Desert Valley Pediatrics to use, disclose and/or obtain protected health information described below.

2. I authorize release of information for the period of health care:

   ☐ all past, present and future period OR ☐ From _____ to _____

3. ☐ (a) I authorize release of my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse)
   OR
   ☐ (b) I authorize release of my complete health record with the exception of the following information:
   - ☐ mental health records
   - ☐ communicable diseases (including HIV and AIDS)
   - ☐ alcohol/drug abuse treatment
   - ☐ other: _____

4. ☐ I authorize this information to be **released** to:
   Name/Facility: _____
   Address: _____
   City: _____
   Phone: _____ Fax: _____

   ☐ I authorize this information to be **obtained** from:
   Name/Facility: _____
   Address: _____
   City: _____
   Phone: _____ Fax: _____

5. This authorization shall be in effect for **90 days** unless otherwise specified.

6. I understand I have the right to revoke this authorization in writing at any time.
   I understand a revocation is not effective to the extent that any person has acted in reliance of my authorization.

By signing this form, I acknowledge that I have read it in full, understand it, and agree to its terms.

Signature of Patient's Parent/Guardian: _____ **Date** _____/_____/_____

Printed Name: _____ **Relationship to patient:** _____