DVPeds
Desert Valley Pediatrics

4137 N. 108th Avenue, Phoenix, AZ 85037
3802 N. 53rd Avenue, Suite 160, Phoenix, AZ 85031
4840 E. Indian School Rd., Suite 100, Phoenix, AZ 85018
15264 W. Brookside Lane, Suite 155, Surprise, AZ 85374
700 N. Estrella Parkway, Suite 110, Goodyear, AZ 85338
(623) 877-7337 | www.dvpeds.com

Release of Health Information

Below are the fees related to releasing medical records. This form should only be completed by a parent or guardian. Once your request is being processed, the office staff will contact you for prepayment.

- For records released on a disc that are picked up in the office, the charge is $10.00
- For records released on a disc mailed to you, the charge is $15.00
- For printed records that are picked up in the office, the charge is $20.00
- For printed records that are mailed to you, the charge is $25.00

We do not charge for releasing a copy of your child's vaccine record, however we do require a signed release of health information form.

Records released to a new PCP for continuing patient care are released free of charge, with a signed release of health information form, as a courtesy.

All records requests are generally completed in 3-5 business days.

Desert Valley Pediatrics
Authorization for Release of Health Information

Phone: 623-877-7337 Fax: 623-772-0686

☐ West Valley Office	☐ At The Ball Park	☐ Goodyear Office	☐ Surprise Office
4137 N 108th Ave Phoenix, AZ 85037	3802 N 53rd Ave Ste. 160 Phoenix, AZ 85031	700 N Estrella Parkway Ste. 110 Goodyear, AZ 85338	15264 W Brookside Ln Ste. 155 Surprise, AZ 85374

Patient Name: _____ **DOB:** ____/____/_____
(One form per patient)

Current Address: _____
(Street) (City) (Zip Code) (State)

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:
   Choose one
   ☐ All past, present and future period
   ☐ From _____ to _____

3 **Choose one:**
   ☐ (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)
   ☐(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 Desert Valley Pediatrics to:
   ☐ Obtain this information from
   ☐ Release this information to

   Name/Facility: _____
   Address: _____
   City: _____ State: _____ Zip Code: _____
   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 on my authorization.

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

Phone #: _____ Preferred Method (circle one): Paper Disc

Printed Name: _____ Relationship to patient: _____

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