Release of Health Information

This form should only be completed by a parent or guardian.

If you are requesting the completion of FMLA forms you must complete the Release of Health Information to have this form faxed or mailed to you or any other party (form not necessary for pick-up by parent/guardian).

Prepayment is required for all record and FMLA requests; the fee is $25 for each request. You may pay in office or by calling our billing department at

623-877- PEDS (7337).

We do not charge for releasing only a copy of your child's vaccine record, however we do require a signed release of health information form if you request to have it faxed or mailed to you or any other party.

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	3802 N 53rd Ave Ste. 160	700 N Estrella Parkway Ste. 110	15264 W Brookside Ln Ste. 155
Phoenix, AZ 85037	Phoenix, AZ 85031	Goodyear, AZ 85338	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** ___/___/____