Desert Valley Pediatrics
Authorization for Release of Health Information

Patient Name: _____ Date of Birth: _____/_____/_____

Current Address: _____

I authorize Desert Valley Pediatrics to:

_____ Receive this information from _____ Release this information to

Name/Facility: _____

Address: _____

Phone: _____ Fax: _____

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

____ Complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).

____ Complete health records **WITHOUT** mental health, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse

____ Office Visits ONLY

____ Labs/Imaging ONLY

____ Hospital/Urgent Care records ONLY

____ Mental Health records ONLY

____ Other: _____

I authorize you to furnish a copy or summary of medical records on the above-named child to the above-named person/facility. I understand this authorization shall be in effect for 90 days unless otherwise specified. 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. I release you from all legal responsibility of liability that may be derived from this authorization.

_____ _____

Printed Name Relationship to Patient

_____ _____

Parent/Legal Guardian Signature Date