Desert Valley Pediatrics
Authorization for Release of Health Information

623-877-7337
Locations and Fax Numbers
West Valley 623 772 0686 **Buckeye** 623 267 4727**Goodyear** 623 932 2443
Surprise 623 214 3219 **Ballpark** 623 247 6537 **Arcadia** 602 956 0773
www.dvpeds.com

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.

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

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