All About Kids Pediatrics
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Tempe, AZ 85283
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# Authorization to Send or Forward Health Information

Patient Name: ______________________________Date of Birth: ___________________________________

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. All About Kids Pediatrics, its employees, staff, and representatives are authorized to make the disclosure.

3. The type of information to be used or disclosed is as follows (check the appropriate boxes)

□ problem list □ medication list □ immunization records □ lab results
□ most recent visit/physical □ x-ray and imaging report □ consultation report □ entire record
□ other: ______________________________________________

4. I understand that the information in my child's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. The information identified above may be used by or disclosed to the following individual or organization:

Name: ___________________________________ Facility: _______________________________________

Address: ______________________________________________________________________________

City: ____________________________________ State: __________ Zip code: ______________________

Phone Number ___________________________ Fax Number ___________________________________

**Information will not be released without the adequate information of the name, fax or address of the physican or facility.**

6. This information for which I'm authorizing disclosure will be used for the following purpose:
□ my personal records □ sharing with other health care providers □ other: _____________________

7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

8. This authorization will expire or 1 year or (insert date of event):__________________

9. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

10. I understand authorizing the use of disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

__________________________________ ______________________________
Signature of parent or legal representative Date

If signed by legal representative, relationship to patient: _________________________________