All About Kids Pediatrics
7517 S McClintock Dr. Suite 103
Tempe, AZ 85283
480-820-3188 Fax 480-838-5033

Authorization to Receive Health Information

Today's Date: _____ Patient Name: _____

Date of Birth: _____

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

2. The following individual or organization listed is authorized to make the disclosure to All About Kids Pediatrics.
Name: _____ Facility: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone: _____ Fax: _____

Information cannot be obtained without the complete address and name of the physician or facility.

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 reports □ 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. 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: _____

6. 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.
7. This authorization will expire (insert date of event):_____
If I fail to specify an expiration date this authorization will expire one year from the date on which it was signed.
8. I understand that once the above information is disclosed, it may be redisclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
9. 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: _____

Date: _____

Signature of Witness: _____ Date: _____