16611 S 40th St Suite#160
Phoenix, AZ 85048
Phone# 480-940-8527
Fax# 480-940-8530

Release and Authorization for Use or Disclosure of Protected Health Information

Patient Name: ______________________________ **Date of Birth:** _______________________________

Address: ____

____

Telephone: ____

I authorize **TLC Pediatrics** to disclose/release the following information:

_____ All medical records related to (specify condition, treatment, etc.): _______________________________________

_____ All billing records related to (specify condition, treatment, etc.): ____

_____ Specific records/information as follows: ____

____

Purpose of disclosure: ____

I do not want the following information disclosed (as defined by applicable state and federal laws):

_____ Alcohol/Drug Abuse _____ HIV Test Results _____ Mental Health/Developmental Disabilities

Release information TO:

Address: ____

____

Telephone: _________________ **Fax:** _______________________

This Authorization is good until the following date: ____
Note: If this item is left blank, the authorization will expire in one (1) year from the date signed.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the disclosing medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

____	____
Signature of Patient or Personal Representative	Date
____	____
Printed Name of Patient or Personal Representative	Address
____	____
Description of Personal Representative's Authority	Telephone