ESTRELLA PEDIATRICS, P.C.
9305 W. THOMAS ROAD, SUITE 125
PHOENIX, AZ 85037
PHONE: (623) 388-3216 FAX: (623) 388-4902
Medical Records Fax: 623-225-7967

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name: _____ Name of Parent/Legal Guardian: _____

Patient's Date of Birth: _____ Telephone Number: _____

Check one: □**RELEASE** a copy of the following information concerning the above named patient **TO**:

□ **RECEIVE** a copy of the following information concerning the above named patient **FROM**:

Practice Name: _____ Practice Address: _____

Practice Phone: _____ Practice Fax: _____

Only this information will be disclosed by this authorization (records to be included):

_____ All Medical Records _____Immunization Records Only_____Other, Please Specify: _____

If applicable, I also give permission for the following to be disclosed (**please initial**):
____ acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV)
____ behavioral health services/psychiatric care
____ treatment for alcohol and/or drug abuse

Reason for Records Release:
□ Change of Insurance □Relocation/Distance □Transitioning to Adult Practice
□ Dissatisfaction due to: _____ □Other _____
May we contact you for details? □ Yes □ No

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 Practice. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. **If I fail to specify an expiration date, event or condition, this authorization will expire in One Year from date signed.**

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. The Practice, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____

Patient or Personal Representative's Signature Relationship to Patient Date

_____

Witness Relationship to Patient Date

(REV 3/2012)

Effective Date 04/14/03
Revision Date: 10/09/2017