9305 W. THOMAS ROAD, SUITE 125
PHOENIX, AZ 85037

ESTRELLA PEDIATRICS, P.C.

PHONE: (623) 388-3216
FAX: (623) 388-4902

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name: _____ _____
First Name **Last Name**

Patient's Date of Birth:_____ Phone number: _____

Patient or Personal Representative's Name: _____ _____
First Name Last Name

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

_____ All Medical Records _____Physical Form
_____ Immunization Records Only _____ Excuse Note
_____ 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/psychiatricare
_____ Treatment for alcohol and/or drugabuse

Name of person/place receiving information: _____***

Release information via the following method: (please select choice):

○ Mail: _____ _____ _____
Mailing Address City Zip Code

○ Fax: _____

○ Email: _____ (Be aware that emailing may not be secure)

○ Will pick up in person

○ Other: _____

Reason for Records Release: (please select choice)

○ Change of Insurance ○ Relocation/Distance

○Transitioning to Adult Practice ○ Dissatisfaction due to:_____

○ Other:_____

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. **If I fail to specify an expiration date, event or condition, this authorization will expire in One Year from datesigned.**

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 authorizedherein.

Patient or Personal Representative's Signature: _____

Date: _____ Relationship to Patient: _____