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

# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Phone Number: _____
Date of Birth: _____ Soc. Sec. No: XXX-XX
Address: _____

I hereby authorize Estrella Pediatrics, P.C. to:

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: _____

Records to be included: (Check all that apply)
_____ All Medical Records
_____ Copies of medical records for the period of: ____/____/____ to ____/____/____
Mo Day Yr. Mo Day Yr.
____ Immunization Records
____ Consult Reports
____ Lab, X-Ray

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 are
____ treatment for alcohol and/or drug abuse

This information is to be disclosed for the purpose of: _____

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. If I have questions about disclosures of my health information, I can contact the Privacy Officer at (623) 388-3216.

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.

I have requested a copy of this Release. ____ YES ____ NO

_____
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: 05/09/2017