Authorization to Disclose Health Information

I, the undersigned, authorize Pediatrix to release my health information as noted be

Please return this COMPLETED authorization form to your Physician's Office.

Jay Caruthers- Office Manager
15650 N. Black Canyon Ste. 100
Phoenix, AZ 85053
p: 602-866-0550 f: 602-993-5788
2030 W. Whispering Wind Dr.
Phoenix, AZ 85058
P: 623-869-9080 F: 623-869-9090
www.pediatrixmd.com

Patient Information:

All sections must be completed in order for request to be processed

Patient Full Name: _____ Other Names During Treatment _____

Patient Address:_____ Date of Birth: _____

City: _____ State: _____ Zip:_____ Phone Number: _____

Release Information To

This section must be complete in order for the request to be processed

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip:_____ Fax Number: _____

Purpose of Request: _____

Examples: Continuation of Care, Legal, Insurance, Patient Personal Use, Other (please explain).

Payment Information

PAYMENT OPTIONS: Check, Credit Card or Money Order.

Charges outlined below will be applied for all copies released directly to patient or sent on patient's behalf.

Invoice must be paid before records will be released

A.R.S 12-2295: Except as otherwise provided by law, a health care provider or contractor may charge a person who requests copies of their medical records or billing records a reasonable fee for the production of the records. Except as necessary for continuity of care, a health care provider or contractor may require the payment of any fees in advance.

******No cost for Doctor to Doctor requests.**

******Routine Request (on a disk, within 2 weeks) no cost to the patients.**

******By Default, the past 2 years of pertinent information will be sent**

******All Immunization Requests will be provided by Pediatrix at no cost.**

Information to be Released

Please provide information for my medical or billing records for the following dates of service:

From_____To_____

- □ History and Physical Examination
- □ Office Visit Note
- □ Laboratory Tests
- □ X-Rays/Imaging Reports
- □ Operative Reports
- □ Pathology Reports
- □ Consultations

Other_____

Form of Records

Please Choose: Patient Must Provide PATIENT 4 Digit Password _____

□ Records on CD --> 4 Digit Encryption Key: _____

□ Records on Paper

Authorization to Release Protected

Required - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical

		Initial Below
I □ DO	□ **DO NOT** want information on ***Mental Health** to be released	_____
I □ DO	□ **DO NOT** want information on ***HIV tests & Related information** to be released	_____
I □ DO	□ **DO NOT** want information about ***Alcohol and/or Substance Abuse** released	_____
I □ DO	□ **DO NOT** want information about ***Communicable Diseases** released	_____

Please confirm that you have placed a checkmark and you have initialed all the protected information categories above regardless if they are applicable or not. If the form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Patient's Signature_____ **Date:**_____

(Required for all patients 18 years and older for psychiatric records, 14 years and older for substance use records)

Signature of Parent or Legal Guardian_____ **Date:**_____

(Required for all patients under the age of 18 unless otherwise allowed by law. If person authorizing this disclosure is not the parent, legal representation documentation must be supplied)

-This authorization will expire 90 days from the date appearing above. I understand I may revoke this authorization at any time by notifying the Health Information Management Department in writing. If I revoke this authorization, there will be no effect on the actions the hospital took before receiving the revocation.

-I understand that under the applicable law the information used pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be subject to the protections of the privacy standard.

-I understand that my treatment or continued treatment by Pediatrix and its affiliates is no way conditioned on whether or not I sign the authorization. I understand I may refuse to sign the authorization at any time.

-I understand I may inspect or copy the information that is used or disclosed.