



Pimri Pediatrics

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I voluntarily consent to an authorize my (my child's) health care provider:

_____ (practitioner/hospital)

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

to use or disclose my (my child's) health information during the term of this Authorization to the recipient(s) that I have identified below.

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Recipient: I authorize my health care information to be released to the following recipient(s):

Nicolas Peters, MD, MD(H)
Pimri Pediatrics
70 S Val Vista Dr, Suite A3-618, Gilbert, AZ 85296
Phone: 480-485-5166 Fax: 877-991-6652 (HIPPA compliant)

Purpose: I authorize the release of my health information for the following specific purpose:

_____ Continuity of care _____

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.¹
- Only the following records or types of health information:

<input type="checkbox"/> History and Physical	<input type="checkbox"/> Clinic Notes
<input type="checkbox"/> Radiology Results	<input type="checkbox"/> Growth Charts
<input type="checkbox"/> Consult notes	<input type="checkbox"/> Immunization records
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Operative Notes
<input type="checkbox"/> Laboratory/Pathology results	
<input type="checkbox"/> Other: _____	

¹ NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records.

Term: I understand that this Authorization will remain in effect:

- From the date of this Authorization until the _____ day of _____, 20____.
- Until the Provider fulfills this request.
- Until the following event occurs: _____

Redisclosure: I understand that my (my child's) health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at **Pimri Pediatrics**. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to **Pimri Pediatrics** at the address listed below. The revocation will be effective immediately upon my (my child's) health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Signature

Date

If Individual is unable to sign this Authorization, please complete the information below:

Name of Guardian/
Representative

Legal Relationship

Date