Pediatrics West, P.C.
health care for the growing years

Authorization/Release for Protected Health Information (PHI)

_____

Patient Legal Name Date of Birth

_____

Address Phone#

_____

City State Zip Code

I hereby authorize the following facility to disclose Protected Health Information of the patient listed above.

Requested Delivery Method: 0 Mail 0 Pick Up 0Email/Fax: _____

Facility/Doctors Name

From: _____ To: _____

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Phone# _____ Phone# _____

Fax# _____ Fax# _____

Reason for Transfer: _____

Type of Access Requested: **Specific Date Range Requested:**

○ Copies of Records	○ Entire Record ○ Pertinent info only ○ History & Physical ○ Consult Report ○ Operative Report ○ Rehabilitation Services	○ Lab ○ Imaging/Radiology ○ Cardiac Studies ○ Demographics ○ Nursing Notes ○ Medication Record	○ Progress Notes ○ Physician Orders ○ Billing Records ○ Immunizations ○ Other

This authorization shall expire upon:

Fulfillment of this request Date: _____

- I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information.
- I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.
- The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.
- I understand that the term Complete Chart for release of Protected Health Information mean that only Records generated by this facility will be released.
- I have read the above and authorize the disclosure of the protected health information.
- For closed clinics there will always be a fee for copying of records.

_____

Signature of Patient/Parent/Legal Guardian **Date**