TUCSON CENTRAL PEDIATRICS

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1) I authorize Tucson Central Pediatrics to disclose protected health information from the health records of:

   Patient name_____ DOB_____
   Address_____ City_____State____ZIP____
   Phone number_____ SS# _____

   Covering periods of health care from (date)_____ to (date)_____

2) This information is to be disclosed to: (recipient)

   Name _____
   Address_____
   _____

3) Information to be disclosed: _____ Complete health records OR
   ____ Office notes ____Laboratory tests ____Consultation reports
   ____ Radiology reports ____Itemized bills ____ other _____

3) Purpose or Description of how information will be used: _____
   _____

4) I understand that this may include information relating to the following and I agree to its release unless I indicate NO
   Yes____/No____ AIDS or HIV infection
   Yes____/No____ Behavioral Health care
   Yes____/No____ Treatment for alcohol and/or drug abuse
   Yes____/No____ Genetic counseling or testing
   Yes____/No____ Testing for pregnancy and/or sexually transmitted diseases

5) I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken based upon the authorization. Unless otherwise revoked, this authorization will expire after 2 years, unless otherwise stated. Further authorizations should be completed and signed on a separate form.

6) Tucson Central Pediatrics, its employees, directors, and medical staff members are released from any legal liability for disclosure of my protected health information to the extent authorized by this form.

7) I understand that Tucson Central Pediatrics will not condition treatment, payment, enrollment or eligibility on obtaining this authorization, except where federal law allows such condition.

8) I understand that if the organization authorized to receive the health information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

9) I understand there will be a fee for copying these records for personal use. In addition, access by review of the original record will have a fee and a time limitation.

_____ _____ _____ _____
Signature of Patient or Legal Representative Date Signature of Witness Date

_____ _____
Printed Name of Representative Relationship to patient