Arvada Pediatric
ASSOCIATES

Authorization/Release of Protected Health Information (PHI)

ONE REQUEST PER PATIENT

Patient Name _____ Date of Birth _____

I hereby consent to the release of Protected Health Information for the above-named patient as follows:

FROM: *Physician/Facility Sending Records*

Name _____
Address _____
City, State, Zip _____
Phone: _____
Fax _____

TO: *Receiving Entity*

Name _____
Address _____
City, State, Zip _____
Phone: _____
Fax _____

Information to be released:

☐ Problem list, growth chart, immunization record
☐ All health information
☐ Only those records specified as follows: _____

IF PATIENTS ARE 13YRS OR OLDER, THEY MUST SIGN FOR THE FOLLOWING:
I specifically consent to the release of information relating to:

☐ Substance abuse (including drug/alcohol abuse)
☐ Mental health (including psychotherapy notes)
☐ Sexually transmitted diseases and HIV related information
☐ Contraception and pregnancy counseling/evaluation

Signature: _____ Name: _____

Purpose of disclosure: ___ Changing physicians ___ Consultation ___ Other (please specify): _____

1. I understand that this consent will expire 60 days after the date I have signed this form.
2. I understand that I may revoke this consent at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that I am not required to sign this consent and that the organization to which this information is released may not condition treatment or coverage on my providing this consent, except as may be permitted by law.
4. I understand that information used or disclosed pursuant to this consent may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations.

Signature of patient or authorized representative _____ Date_____

PRINT patient/authorized representative _____ Relationship to patient _____