Authorization for the release, use or disclosure of health information

I request release of my child's medical record including vaccinations and growth charts.

	From	To
Office Name:		Pleasant Pediatrics
Address:		9059 W Lake Pleasant Pkwy, Ste E540 Peoria, AZ- 85382
Phone:		623-322-3380
Fax:		623-322-4399

I authorize Pleasant Pediatrics to use or disclose protected health information relating to the health records and information, medical history, mental and/or physical condition, and services rendered to:

CHILD:

First Name Last Name DOB

___________________ _________________ ______________

Indicate specific records for continuation of care:

___ Entire chart
___ Health information for the dates(s): ______________
___ Immunization record
___ Growth charts
___ Other: ______________________________________

I understand this may include information relating to AIDS, HIV Infection, Psychiatric Care, and/or treatment for alcohol and or drug treatment.

I understand this authorization may be revoked in writing at any time, according to the instructions in the Pleasant Pediatrics Notice of Privacy Practices and Procedures, except to the extent that action has been taken in reliance on this authorization Unless otherwise revoked, this authorization will expire sixty (60) days from the date of authorization.

I further understand that I have a right to receive a copy of this authorization.

____ _____________________________________
Parent/ Legal Guardian Name (print) Relationship to Patient

____ _______________________
Parent / Legal Guardian Signature Date