



4545 E. Chandler Blvd., Suite 104, Phoenix, AZ 85048 Phone: 480-496-6444 Fax: 480-496-9688

Authorization for the Use or Disclosure of Protected Health Information

As set forth more fully in our Notice of Privacy Practices, we are required by law to obtain your authorization for any use or disclosure of your health information for purpose other than treatment, payment or health care operations. You have a right to review our Notice of Privacy Practices before signing this Authorization:

(Patient Name – First, Middle, Last) (Date of Birth)

(Additional Patient Name – First, Middle, Last) (Date of Birth)

I authorize Ahwatukee Pediatrics, P.C. to: Please check one of the following:

1. Obtain protected health information from the following location

(Name of Authorized Person, Agent or Physician) (Phone Number including area code)

(Company, Hospital or Practice) (Fax Number including area code)

(Address/Street) (City/State/Zip)

2. Release my protected health information to the following

(Name of Authorized Person, Agent or Physician) (Phone Number including area code)

(Company, Hospital or Practice) (Fax Number including area code)

(Address/Street) (City/State/Zip)

The following information from my medical records:

- All health information including, but not limited to AIDS/HIV and other communicable diseases information, behavioral health care/psychiatric care, alcohol and or drug treatment, if any, unless specifically accepted: _____
- History and Physical
- Laboratory Reports
- Immunizations
- Other _____

Guardian Signature _____ Date _____

Please allow 2 weeks to process your request.