

MESA PEDIATRICS PROFESSIONAL ASSOCIATION

ADMINISTRATIVE OFFICE

6301 S. MCCLINTOCK DR., STE. #101, TEMPE, AZ 85283

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENTS LEGAL NAME _____ PATIENTS DATE OF BIRTH _____

NAME OF PARENT OR LEGAL GUARDIAN _____ RELATIONSHIP TO PATIENT _____

HOME TELEPHONE NUMBER _____ WORK/CELL NUMBER _____

THIS AUTHORIZATION APPLIES TO THE INFORMATION DESCRIBED BELOW. ONLY THIS INFORMATION WILL BE DISCLOSED TO THIS AUTHORIZATION.

- 1. _____ PATIENT SUMMARY
- 2. _____ IMMUNIZATION RECORDS
- 3. _____ GROWTH CHART
- 4. _____ OTHER: _____

BY SIGNING THIS FORM, I AUTHORIZE MESA PEDIATRICS PROFESSIONAL ASSOCIATION TO REQUEST AND/OR DISCLOSE THE PROTECTED HEALTH INFORMATION REGARDING THE PATIENT LISTED ABOVE TO THE FOLLOWING:

NAME OF PHYSICIAN/ FACILITY _____

ADDRESS _____

CITY, STATE, ZIP CODE _____

REASON FOR REQUEST: _____

IF RECORDS ARE BEING DISCLOSED TO A PARTY OTHER THAN A MEDICAL FACILITY OR ANOTHER PROVIDER FOR THE CONTINUATION OF CARE OF THIS PATIENT, **PLEASE CHECK ONE OF THE FOLLOWING:**

- _____ THE RECORDS ARE BEING RELEASED TO A CUSTODIAL PARENT
- _____ THE RECORDS ARE BEING RELEASED TO A LEGAL GUARDIAN
- _____ THE RECORDS ARE BEING RELEASED TO AN ATTORNEY/ ATTORNEY'S OFFICE OR COURT

PLEASE CHECK ONE OF THE FOLLOWING:

- _____ INSPECTION OF RECORDS ONLY (PLEASE SCHEDULE AN APPOINTMENT TO REVIEW RECORDS)
- _____ COPYING CHARGES, \$30.00 FOR CHARTS UP TO 100 PAGES, \$45.00 FOR OVER 100 PAGES

PLEASE CHECK HOW YOU WOULD LIKE TO RECEIVE THE INFORMATION:

- _____ I WILL PICK UP COPY. MPPA WILL NOTIFY YOU WHEN INFORMATION IS READY.
- _____ BY MAIL. I WOULD LIKE THE INFORMATION MAILED TO THE FACILITY/PROVIDER LISTED ABOVE.

I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION IN WRITING AT ANY TIME BY SENDING A SIGNED AND DATED WRITTEN STATEMENT TO MESA PEDIATRICS PRIVACY OFFICER, MESA PEDIATRICS ADMINISTRATIVE OFFICE, 6301 S. MCCLINTOCK DR., STE. #101, TEMPE, AZ 85283 SAYING THAT I AM REVOKING MY AUTHORIZATION TO DISCLOSE HEALTH RECORDS, EXCEPT TO THE EXTENT THAT THE PERSON(S) AND/OR ORGANIZATION NAMED ABOVE HAVE TAKEN ACTION IN RELIANCE ON THIS AUTHORIZATION. THIS AUTHORIZATION WILL EXPIRE AT MIDNIGHT ON _____(DATE).

SIGNATURE OF PARENT OR LEGAL GUARDIAN

DATE _____

FOR MPPA USE ONLY			
AUTHORIZATION FORM REC'D ON _____		COPY OF RECORDS PROVIDED ON _____	
BY _____	DATE _____	DATE _____	INITIALS _____
AUTHORIZATION FOR DISCLOSURE APPROVED		_____ YES	COPIES SENT VIA _____ MAIL
		_____ NO	_____ FAX
			_____ PICKED UP