MESA PEDIATRICS PROFESSIONAL ASSOCIATION

☐ **Chandler Office – 60 S. Kyrene Rd., Ste. 1, Chandler, AZ 85226, Fax: 480-785-8787**
☐ **Gilbert Office – 2550 E. Guadalupe Rd., Ste. 115, Gilbert, AZ 85234, Fax: 480-632-1533**
☐ **San Tan Office – 3592 S. Atherton Blvd., Ste. 1, Gilbert, AZ 85297, Fax: 480-214-2171**
☐ **Tempe Office – 6301 S. McClintock Dr., Ste. 101, Tempe, AZ 85283, Fax: 480-897-2799**

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: ____________________

REASON FOR RECORDS RELEASE:

☐ CHANGE OF INSURANCE/COST ☐ RELOCATION/DISTANCE
☐ TRANSITIONING TO ADULT PRACTICE ☐ LACK OF APPOINTMENT AVAILABILITY
☐ DISSATISFACTION DUE TO: ______________________________
☐ OTHER REASON: ______________________________

MAY WE CONTACT YOU FOR DETAILS? ☐ YES ☐ NO

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

1. ____ PATIENT SUMMARY 2. ____ IMMUNIZATION RECORDS 3. ____ GROWTH CHART 4. ____ ALL RECORDS

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: ____________________

FAX #: ______________________________

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, $6.50

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.
________ BY FAX

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

PROCESSED BY: ________________ **DATE:** ________________