



AV Pediatrics, Allergy & Family Medicine

AUTHORIZATION FOR RELEASE OF PATIENT-IDENTIFIABLE HEALTH INFORMATION

Patient Name: _____ DOB: _____

Address: _____

City _____ State _____ Zip _____ Phone #: _____

I hereby authorize:

Provider, Facility or Individual Name

Address

Phone Number Fax Number

To Release my Records to:

AV Pediatrics, Allergy & Family Medicine
1523 West Avenue J #7
Lancaster, CA 93534
661-945-2221 ext. 201 Fax: 661-729-8234

The type and amount of information to be used or disclosed is as follows:
(include dates where appropriate)

___ Progress Notes from _____ to _____

___ Lab Reports from _____ to _____

___ Radiology Reports from _____ to _____

___ Consultation Reports Dr. _____

___ Immunization Records

___ Proc/Op & Pathology from _____ to _____

___ Any and All records

___ Other: _____

*Please see reverse side for additional instructions

Patient's Name: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event of condition _____. If I fail to specify an expiration date, this authorization will expire six months from the date on which it was signed. This authorization covers only the records and time period(s) specified above.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact (661) 945-2221 and request to speak with the HIPAA Privacy, Security & Compliance Officer.

Signature of Patient/Legal Rep.
(Specify relationship if Legal Rep.)

Relationship to Patient

Date: _____