Authorization for the Use or Disclosure of Health Information

Patient name:______________________________ Date of birth:____________________

I request release of my child's health information

From:	**To:**
Office Name:__________________________________	Children's Oasis Pediatrics 1425 W. Elliot Rd., Suite #204
Doctor's Name:________________________________	Gilbert, AZ 85233 (480) 792-1012
Address:______________________________________	fax (480) 792-1013
Phone Number:_________________________________	
Fax Number:___________________________________	

The health information to be used/disclosed includes: (check all that apply)

____ All health information including but not limited to AIDS/HIV and other communicable disease information, behavioral health care/psychiatric care, alcohol and or drug abuse treatment, if any, unless specifically excepted:____

____ Health information relating to the following condition:_____________________________

____ Health information for the date(s): ______________________________________

____ Immunization record

This authorization ends: ____ on this date _____________.

___ 6 months from the date of authorization.
(default if no box checked)

I understand I do not have to sign this authorization in order to get health care benefits. I understand that I may revoke this authorization in writing at any time except to the extent that Children's Oasis Pediatrics has acted in reliance upon this authorization. Once the office discloses health information the person or organization that receives it may redisclose it as privacy laws may no longer protect it.

Signature of parent/legal guardian;________________________ Date:____________________

Relationship to Patient:____________________________