Moon Valley Pediatrics

14001 N 7th Street . Suite G-114 . Phoenix, AZ 85022
Phone: 602-298-6930 Fax: 602-298-6918

Authorization for the release, use or disclosure of health information

I request release of my child's medical records including vaccinations record and growth charts.

	From	To
Name of Office:		Moon Valley Pediatrics
Address:		14001 N 7th St Suite G-114 Phoenix, AZ 85022
Phone:		602-298-6930
Fax:		602-298-6918

I authorize Moon Valley Pediatrics to use or disclose protected health information relating to the health records and information, medical history, mental and/or physical condition, and services rendered to:

PATIENT:

First Name Last Name DOB

_____ _____ _____

Indicate specific records for continuation of care:

___ Entire chart
___ Health information for the dates(s): _____
___ Immunization record
___ Growth charts
___ Other: _____

I understand this may include information relating to AIDS, HIV Infection, Psychiatric Care, and/or treatment for alcohol and or drug treatment.

I understand this authorization may be revoked in writing at any time, according to the instructions in the Moon Valley Pediatrics' Notice of Privacy Practices and Procedures, except to the extent that action has been taken in reliance on this authorization Unless otherwise revoked, this authorization will expire sixty (60) days from the date of authorization.

I further understand that I have a right to receive a copy of this authorization.

Parent/ Legal Guardian Name (print):_____ Relationship to Patient:_____

Parent/legal Guardian Signature:_____ Date:_____