PAPAGO BUTTES PEDIATRIC CENTER, P.C.

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PATIENT/LEGAL GUARDIAN CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

RECORDS TO BE SENT FROM PAPAGO BUTTES PEDIATRIC CENTER, P.C.

PATIENTS NAME: _____ DATE OF BIRTH: _____
PATIENTS NAME: _____ DATE OF BIRTH: _____
PATIENTS NAME: _____ DATE OF BIRTH: _____
PATIENTS NAME: _____ DATE OF BIRTH: _____

By signing this consent form, I authorize Papago Buttes Pediatric Center, P.C. to use and/or disclose certain **protected health information (PHI)** about my child/children (listed above) in the form specifically listed below. And I authorize this information to be released to the party/parties specifically listed below. I understand you will only be able to forward PHI generated by this office.

PLEASE PROVIDE A REASON FOR PHI TRANSFER: _____
(MOVING, CHANGING DR'S, INSURANCE CHANGE, ETC..)

With my consent Papago Buttes Pediatric Center, P.C. may disclose the following PHI:

- ☐ All health information from patient records for the following dates:
  From:_____/_____/_____ To:_____/_____/_____
- ☐ All health information from patient records related to the following condition:
  _____
- ☐ X-Rays taken in the office on _____/_____/_____, date if service,
- ☐ Complete the attached medical, school, camp, immunization, or other form listed below:
  Other: _____
- ☐ Billing information from _____/_____/_____ to _____/_____/_____.
- ☐ Other, please be specific: _____
  _____

With my consent Papago Buttes Pediatric Center, P.C. may disclose the above PHI to the following:
I understand there may be a fee of $25.00 for me to receive a copy of my records.

- ☐ I will pick up the information when ready, please call me at: _____
- ☐ Please mail the information to the house address listed in our medical and billing records.
- ☐ By fax to the following person and fax number only:
  Persons name: _____ Fax number: _____
- ☐ Please mail to the following name and address:
  Company name: _____
  Attn: _____
  Address: _____
  City/State/Zip: _____
  Telephone: _____
- ☐ Other, please be specific: _____

I understand once the office discloses health information, the person or organization that I designated to receive the information may redisclose it as privacy laws may no longer protect it.

I understand that if this office has requested this authorization, I have a right to receive a copy of it.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed name if signed on behalf of the patient Relationship (parent, legal guardian,etc…)